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Florida's Proposed Good Samaritan Statute–It Does Not Meet the Problem

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FLORIDA'S PROPOSED GOOD SAMARITAN STATUTE— IT DOES NOT MEET THE PROBLEM

Within the past several years a rash of "Good Samaritan" statutes have been enacted in many states.[1] These statutes are designed to insulate physicians from civil liability for injuries caused by emergency medical treatment rendered at the scene of an accident.

The Florida Legislature considered such an immunity proposal in 1963,[2] but it was not enacted into law. Whether it should be enacted, altered, or forgotten is the subject of this note. The problem will be focused against the background of the common law and the considered opinions of those most affected by the proposal, the physicians themselves.

THE PROBLEM

The Physician's Standard of Care in Florida

In order to avoid liability the Florida physician must be responsible for the use of "ordinary skill and diligence" and for application of the "means and methods ordinarily and generally used by physicians of ordinary skill and learning" in determining the "nature of the ailment" and in acting upon this honest conclusion.[3] The physician meets the standard if he applies the means and methods of a "respectable minority" of the medical profession.[4] His skill is also measured in light of the standards of "local practice."[5]

This standard implicity necessitates an expert witness from the local medical community. This means that the standard of care is "fixed within the profession itself."[6] The plaintiff's case is burdened

1. Alaska Laws 1962, ch. 6, No. 225; Ark. Acts 1963, No. 46; CAL. BUS. & PROF. CODE §2144; Conn. Laws 1963, No. 205; Ga. Laws 1962, No. 852; Ind. Laws 1963, ch. 319; Me. Laws 1961, ch. 265; Md. Laws 1963, ch. 65; Mass. Laws 1962, ch. 217; Mich. Laws 1963, No. 17; Miss. Laws 1962, ch. 413, No. 132; Mont. Laws 1963, ch. 93, No. 124; Neb. Laws 1961, ch. 110, No. 517; Nev. Laws 1963, ch. 219; N.H. Laws 1963, ch. 256; N.J. Laws 1963, ch. 140; N.M. Laws 1963, ch. 59; N.D. Laws 1961, ch. 287, No. 207; Okla. Laws 1963, ch. 87, No. 206; Ohio Laws 1963, No. 14; Pa. Laws 1963, No. 301; S.D. Laws 1961, ch. 137, No. 509; Tenn. Laws 1963, ch. 46; Tex. Laws 1961, ch. 317, No. 100; Utah Laws 1961, ch. 135, No. 191; Va. Laws 1962, ch. 449; Wis. Laws 1963, ch. 94; Wyo. Laws 1961, ch. 42.

2. Fla. H.B. 411 (1963).

3. Hill v. Boughton, 146 Fla. 505, 511, 1 So. 2d 610, 613 (1941).

4. Baldor v. Rogers, 81 So. 2d 658, 660 (Fla. 1954) citing Dahl v. Wagner, 87 Wash. 492, 495, 151 Pac. 1079, 1080 (1915).

5. Hill v. Boughton, *supra* note 3; Olschefsky v. Fischer, 123 So. 2d 751 (3d D.C.A. Fla. 1960); Crovella v. Cockrane, 102 So. 2d 307 (1st D.C.A. Fla. 1958).

6. Scott & Herring, *Medical Malpractice in Florida*, 12 U. FLA. L. REV. 121, 125 (1959).

even further by the decided reluctance of many doctors to provide expert testimony for the plaintiff.[7]

As noted, when the malpractice plaintiff sues on an injury incurred under normal circumstances he is faced with overcoming a standard of care very favorable to the medical practitioner. The accident emergency, however, is not a normal situation. The circumstances contemplated by this note are those in which there is no hospital, no officer, and none of the medical aids common to modern practice — simply a doctor, his black bag, and an injured person. A typical case would be the victim of an automobile accident. What is the standard of care in this type of medical emergency? Apparently it is the same standard, that of ordinary skill and diligence previously adverted to, which applies to the office-visit patient. Hence, the pressure of the emergency situation is not afforded explicit recognition in the attempt to affix liability.

The Abandonment Doctrine

In addition to the office-visit standard of care, the physician rendering roadside emergency care is faced with an additional responsibility. Once the patient-physician relation is established, there can be no abandonment by the doctor without, in fact, providing a competent replacement or without giving reasonable notice of cessation of services in order that the patient might secure a doctor of his own choice.[8] Practically speaking, this means the physician must follow the emergency victim to the hospital and either secure a replacement or continue his care. This is a bothersome requirement that forces the medical practitioner to abandon his present business (for example, a hospital round followed by scheduled office hours) and serve an unknown person to the neglect of his regular patients. Quite obviously, this rule imposes a very real hardship on the out-of-state physician on vacation in Florida. Any physician might be very willing to stop, but the burden of "continued relation" often prevents him.[9]

At this point it should be manifest that the law gives the doctor little inducement to stop at an accident. It imposes an office-visit standard of care where there is no office or the normal medical facilities necessary to a proper diagnosis of the injury. It holds him to a continued relationship, even though the original interrelation was fortuitous and in response to an humanitarian impulse.

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7. *Id.* at 136.

8. Norton v. Hamilton, 92 Ga. App. 727, 89 S.E.2d 809 (1955); McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950); Saunders v. Lischkoff, 137 Fla. 826, 188 So. 815 (1939) (dictum).

9. See replies to survey of Florida physicians, *infra* at note 24.

The Good Samaritan and the Common Law

There have been several cases in which appellate courts were faced with determining the standard of conduct for which the Good Samaritan should be responsible. Two points should be noted regarding these cases. First, the duty of a medical practitioner was not in issue. Hence, the question whether a physician should be or will be afforded the benefits of the Good Samaritan doctrine is subject to speculation. Second, the medical emergencies involved are generally just the kind to which a standard different from the ordinary medical malpractice standard should be applied. The injured person has been grievously hurt under circumstances in which the physician would have to act immediately without benefit of an antiseptic emergency room, diagnostic equipment, medical instruments, or the patient's medical history. In these situations there are several potential courses of action, and a doctor would have been required to select one without benefit of the modern technology that is often a necessary supplement to his skills.

What is the standard of care imposed upon the Good Samaritan? What duties does the law impose on one who gratuitously renders aid to an accident victim?

In *Carey v. Davis*,[10] the defendant's farmhand had suffered heat prostration. The defendant directed that the unconscious plaintiff be moved to a wagon where he lay exposed to the sun for four additional hours. The plaintiff asserted that this exposure resulted in making him sick and wholly incapacitated for work. The court, in finding for plaintiff, held that once a person assumes control over one in "distress," he is "bound to act with reasonable prudence and care" and that an "unavailing" effort should not "increase the injury."[11] Hence, one standard is reasonable care.

In New York the duty is described in different language, but the standard is probably the same. There the "volunteer is charged with a duty of common . . . humanity to provide proper care and attention so that at least the injured party is made no worse."[12]

Regardless of the verbal formula invoked, the defendant is responsible "for *further* injury resulting from lack of proper care."[13] An often litigated situation occurs when the volunteer, with no duty in the first instance to render care, allegedly was unreasonably dilatory

10. 190 Iowa 720, 180 N.W. 889 (1921).

11. *Id.* at 726, 180 N.W. at 892.

12. Clark v. State, 195 Misc. 581, 89 N.Y.S.2d 132 (Ct. Cl.), *aff'd*, 276 App. Div. 10, 93 N.Y.S.2d 28 (1949), *rehearing denied*, 276 App. Div. 940, 94 N.Y.S.2d 202 (1950), *aff'd*, 302 N.Y. 795, 99 N.E.2d 300 (1951).

13. David v. Southern Farm Bureau Cas. Ins. Co., 122 So. 2d 691, 693 (1st Ct. App. La. 1960) (dicta). (Emphasis added.)

in securing aid.[14] One court summed up the extant case law by noting that liability arises in most cases because the "defendant made the situation worse, either by increasing the danger . . . or by inducing him [the injured person] to forego the possibility of help from other sources."[15] To repeat, the "rescuer must worsen the position of the person in distress,"[16] before liability will attach.

Dicta in a leading case,[17] where the court held the "injury aggravation" doctrine applicable, is particularly interesting to the Good Samaritan who is also a physician. The court added an aside to the effect that the defendant would have fulfilled his duty had he, after assuming charge, taken the patient to his family or to a hospital.[18] If this statement were to withstand the test of litigation and the Good Samaritan doctrine were to be applied to the physician, the principle enunciated would abrogate the abandonment doctrine that vexes so many doctors who contemplate stopping to render aid at roadside accidents.[19]

One case in this area runs contra to the law as previously set forth. *Griswold v. Boston & Maine Railroad*[20] enunciates the proposition that there is no right of action against the Good Samaritan who renders emergency assistance. The Massachusetts court rejected the theory that one has a "duty of common humanity" when he assumes charge of a victim.[21] The court noted that such doctrine "would allow an action against a Good Samaritan and let a priest and a Levite go free."[22] Hence, if a jurisdiction should follow *Griswold* the volunteer would have no duty of good judgment or reasonable care and apparently would be liable only for intentional misconduct.

Whether the Florida Supreme Court would adopt *Griswold* and apply it to physicians, thereby rendering a Good Samaritan statute superfluous, is open to question. At any rate, conjecture and speculation avoids the issue at hand. The adoption of the *Griswold* rule *ex necessitate* would involve litigation and appeal. Doctors fear law-

14. Gates v. Chesapeake & O. Ry., 185 Ky. 24, 213 S.W. 564 (1919); David v. Southern Farm Bureau Cas. Ins. Co., *supra* note 13; Dyche v. Vicksburg S. & P. R.R., 79 Miss. 361, 30 So. 711 (1901); Clark v. State, *supra* note 12; Steckman v. Silver Moon, Inc., 77 S.D. 206, 90 N.W.2d 170 (1958); Zelenko v. Gimbel Bros., Inc., 158 Misc. 904, 287 N.Y. Supp. 134 (Sup. Ct.), *aff'd*, 247 App. Div. 867, 287 N.Y. Supp. 136 (1935).

15. Steckman v. Silver Moon, Inc., *supra* note 14, at 211, 90 N.W.2d at 173 (dicta).

16. United States v. DeVane, 306 F.2d 182 (5th Cir. 1962).

17. Gates v. Chesapeake & O. Ry., *supra* note 14, at 33, 213 S.W. at 568.

18. *Ibid.*

19. See replies to survey of Florida physicians, *infra* at note 24.

20. 183 Mass. 434, 67 N.E. 354 (1903).

21. *Id.* at 436, 67 N.E. at 356.

22. *Ibid.*

suits per se — they think the mere bringing of a malpractice suit is a stigma.[23] Hence, *Griswold* is no cure for our immediate ill, getting physicians to stop, because the law as it stands provides the rationalization not to stop.

As should be obvious from the preceding, there is no common law doctrine particularly adapted to solving the problem created by the physician who stops and renders aid, perhaps carelessly, to the victim of an automobile accident or other mishap. The office-visit standard ignores the realities of the circumstances. The liability for abandonment also ignores the very real problem of forcing physicians to cease the work at hand. As noted, the case law dealing with the Good Samaritan does not define the standard of care required of a physician under similar emergency circumstances. In fact, there appears to be no precedent indicating whether a physician would be allowed to share in the advantages of the doctrine of no liability unless the injuries are aggravated.

Any solution to the problem must utilize what the medical practitioner believes his duty ought to be. It is recognized that the physician is at least partially justified in his reluctance to stop and render aid at the scene of an accident. In order to solve the problem then, it is obvious that the attitudes of physicians themselves must be considered.

Results From Survey of Florida Physicians

A recent survey of Florida physicians, conducted by the University of Florida Law Review, included three questions relating to emergency medical care.[24] Although the survey makes no claims concerning the scientific accuracy of its measure of opinion, the answers should be indicative of the prevalent attitude of Florida physicians inasmuch as the findings are the result of impartial inquiry and are not testimony solicited by one with a vested interest in the result.

The first question asked whether a doctor should be held liable for voluntary, on-the-scene, emergency treatment which, "might be legally characterized as negligent." Twelve answered "yes" while an overwhelming majority of sixty-two said "no." The survey solicited comments and these indicated a general lack of understanding of what constituted "legal" negligence. The most recurrent observation was

23. See replies to survey of Florida physicians, *infra* at note 24.

24. The survey was made by Stephen Kahn, a Florida law student. Questionnaires were sent to more than 130 doctors, at least one questionnaire to each county in Florida, with the larger counties receiving more attention than the smaller ones. The names of recipients were selected at random. There were 74 replies.

a feeling that the law failed to recognize that roadside treatment can amount to nothing more than first aid. Also noted was that first aid administered by a doctor was given by the one best qualified to render it. The doctors emphasized that it was impossible to diagnose completely and accurately under such adverse conditions. It was indicated that usually all that can be done is to control bleeding and preserve life until hospital care can be obtained.

The second question inquired whether the doctor's decision to stop at the scene of an accident had been influenced by the knowledge that emergency treatment was subjected to the same test of due care as that applied to a doctor treating his own patients. The response was forty-one "yes" and thirty-three "no."

The final inquiry bluntly asked whether the physician would stop at an automobile accident if his services were obviously needed. It is a discredit to the medical profession that over one-third answered in the negative. Other polls of physicians have shown that up to one-half do not stop at accidents.[25] The comments on this question ranged in emotion from the apologetic to the irate, from the practical to the rash. Some favored the immunity solution. One doctor capsuled his feelings by stating, "No protection, no service." A recurrent chorus was a very real fear of lawsuits, coupled with an observation of the stigma attending a malpractice action. There were, of course, some shallow remarks about the "shyster lawyers" and the avarice and crookedness of the "average lawyer, especially in Dade County." One doctor observed that there were no negligence attorneys when Hipprocates made his oath. As previously noted, many thought the law should recognize that poor conditions at an accident scene are not conducive to adequate diagnosis or treatment and also that physicians are still the best qualified to render assistance under adverse circumstances. One doctor disliked having to travel with the victim to the hospital. There were several adverse comments concerning the duty of a continued relation. Beneath the general bluster, however, was a strong undercurrent of desire to volunteer regardless of the legal implications. Of the sixty-two physicians who thought no liability should attach for "legally negligent" treatment, a slight majority, thirty-two, indicated they would stop regardless of the legal complications.

Research collateral to the survey in the *Journal of the American Medical Association,* as well as other sources, turned up some surprises. As noted earlier, physicians fear malpractice suits and use this to rationalize away their duty to stop at accidents. The medical association journal has twice, in the past three years, explicitly told its readers that the "risk of liability for furnishing . . . emergency medical

25. Newsweek, Sept. 4, 1961, p. 41.

care has been greatly exaggerated."[26] In one issue the fear was expressed that the "exaggeration . . . may lead physicians to neglect their ethical duty to respond to emergency appeals for first aid."[27] Another journal, *Medical Economics,* sponsored a panel discussion of current ethical problems facing the medical practitioner, including the subject of emergency care.[28] The attorney-panelist stated for the readers that there was little risk of a lawsuit arising out of emergency care. He added that the doctor's reluctance to stop was clearly out of proportion to the risk of a lawsuit.[29] Thus two periodicals, with a combined subscription of 373,725 in the medical field, have informed physicians the fear of lawsuits does not justify the reluctance to stop at the scene of an accident. Yet doctors doggedly persist in grasping a phantom fear as a way of rationalizing away a clear-cut ethical duty.

This collateral research also indicated that a "Good Samaritan" statute will not necessarily produce the desired result—care by physicians for accident victims. In the roundtable discussion sponsored by *Medical Economics,* a physician-panelist from Michigan stated that after the state-wide medical association procured passage of an immunity statute, his "county society [was nonetheless] advising physicians to continue to be circumspect in their handling of accident cases."[30]

The American Medical Association is reportedly opposed to the passage of Good Samaritan laws.[31] An association official has stated that states which refuse to pass these laws "are on the right track."[32] Actions, however, often speak louder than words. While the association apparently opposes enactment, the A.M.A. legislative department acts as a clearing house of information on Good Samaritan acts for state legislatures.[33] If the A.M.A. opposes the legislation, why does it actively prepare kits "containing materials on . . . Good Samaritan acts,"[34] an obvious boon to any legislature contemplating passage of an immunity statute?

The replies to the survey of Florida physicians highlight two things: (1) emergency medical treatment is first aid and the law should recognize this fact and, (2) if this is all that is needed, the grant of immunity, argued by some as the only solution, is unnecessary. To elaborate, the proponents of the immunity statutes assert that

26. 185 A.M.A.J. 794 (1963); 180 A.M.A.J. 706 (1962).
27. 180 A.M.A.J. 706 (1962).
28. Medical Economics, Sept. 23, 1963, p. 119.
29. *Ibid.*
30. *Id.* at 126.
31. Newsweek, Sept. 4, 1961, p. 41.
32. *Ibid.*
33. *American Medical Association Board of Trustees Report,* 182 A.M.A.J. 417 (1963).
34. *Ibid.*

the legislation is necessary because doctors do not stop at accidents. The public welfare demands that physicians be encouraged to stop. *Ergo*, give the physician immunity. Yet the survey indicates that two-thirds do stop regardless of personal reservations. Even many of those who believe no legal liability should attach for such treatment feel bound to stop on the basis of a moral obligation. The consensus of Florida medical opinion seems to be that a standard recognizing first aid care would be sufficient.

THE STATUTORY APPROACH

In general, the Good Samaritan statutes are designed to grant immunity from civil liability for acts or omissions of physicians who render medical assistance in an emergency situation. The purpose is to deny a right of action to the victim so as to remove the physician's fear of lawsuits and thereby induce doctors to give medical aid at accident scenes. As noted earlier, this is not necessarily the result of such legislation.

There are variations from the general theme. Some statutes require as a condition to the immunity that the care be given in "good faith"[35] or that the services be gratuitous.[36] Others state that gross negligence dissolves the immunity[37] or that the actor must be licensed under state law.[38] There is very little evidence that any of the statutes thus far enacted have reached the real essence of the problem, and hence these alleged statutory curatives appear to have made no substantial contribution toward increasing the percentage of doctors who stop and render emergency aid.

Florida House Bill 411 (1963)

The Florida Good Samaritan statute, as proposed, is unique in that it fails to grant any immunity whatsoever. The statute reads:[39]

> No doctor of medicine . . . who in good faith and in the *exercise of reasonable care* renders emergency care to the victim . . . at the scene of an accident or emergency, shall be held liable . . . for any civil damages as a result of any act or omission in rendering the emergency care, or as a result of any act, or failure to act, in providing or arranging for further medical treatment or care for the injured person or persons.

35. CAL. BUS. & PROF. CODE §2144.
36. Ga. Laws 1962, No. 852.
37. Md. Laws 1963, ch. 65.
38. Laws of Utah 1961, ch. 135, No. 191.
39. Fla. H.B. 411 (1963). (Emphasis added.)

The most striking anomaly of the bill is the condition precedent to immunity. The treatment must be rendered "in good faith and in the exercise of reasonable care," in order for the physician to be entitled to the beneficence of the proposed legislation. If one of the reasons prompting the legislation was the physician's fear of lawsuits, this bill is no curative at all. The ascertainment of reasonable care *ex necessitate* involves a jury and a trial and the feared stigma of a malpractice suit. The standard of "reasonable care" probably incorporates by implication the "ordinary skill and learning" standard now applied in Florida. In short, the proposed statute gives the physician nothing he does not already have.

It is to be noted, however, that other features of the bill are positive elements of any ultimate solution and should be retained in future proposals. The "immunity" is apparently not limited to treatment of automobile accident victims — any "accident or emergency" qualifies. Putting aside the question whether any immunity at all is granted by the statute, the extension to a broad variety of accidents or emergencies (not including the hospital or office-visit type) is good. Note, however, that only care rendered "at the scene" of the emergency qualifies. This requirement precludes an unwarranted extension of immunity to care after the initial treatment. The bill also purports to eliminate the legal duty of continued treatment, a modification urged by several physicians answering the Florida Law Review survey. The bill extends its nebulous protection to *all* doctors of medicine, regardless of where they are licensed. This feature also is in the public interest — an out-of-state physician is capable of rendering first aid treatment and the abrogation of his duty of further attendance would act as an inducement to stop. These latter facets of the proposed bill all serve to allay the apprehension of physicians and should thus induce more doctors to stop and render aid at an accident.

A Modest Proposal

Any proposal in this area necessarily feels the tug of two conflicting values. On the one hand is the feeling that physicians ought to be responsible for culpable errors in judgment. This value judgment insists that the common law provides adequate protection. Further, doctors have an ethical duty to aid all persons in an emergency.[40] On the other hand, physicians are suit conscious. Lawsuits stigmatize and the present standards do not recognize the poor conditions for medical treatment present at accident scenes.

40. STETLER & MORITZ, DOCTOR AND PATIENT AND THE LAW 334 (1961). See also American Medical Association, Principles of Medical Ethics §5 (1957).

In the writer's opinion, however, absolute immunity is *not* the answer, nor is the present status of the law very conducive to a fair solution of the problem. A statute recognizing the equities on both sides of the coin would do two things: (1) give affirmative statutory recognition that reasonable care at the scene of an accident means reasonable *first aid* care under the circumstances, and (2) remove the duty to render continuing medical care after the initial establishment of the doctor-patient relationship, that is, abrogate the abandonment doctrine. Thus, a doctor stopping at the scene of an accident could administer the initial medical ministrations (for example, apply bandages, splints, or tourniquets), make sure the victim will receive further care (if the injury warrants such) and then be on about his business without the fear of liability. Hence, such legislation would leave the doctor responsible for his reprehensible misconduct, a proposition with which no man can quarrel and yet recognize the realities of accident scene care.

A Typical Case

An illustration should serve to indicate the reasonableness of the above-mentioned proposal. The incident occurred in the following manner and was related by one of the physicians who answered the survey questionnaire. The physician arrived at the scene of an automobile accident. He treated a female victim who had suffered minor cuts and abrasions, apparently caused by being thrown from the car. The physician attended the wounds and then told the woman to go to a hospital to have the remaining asphalt cleaned out of her elbow. The physician went on about his business. He was sued and paid an adverse judgment, apparently on the theory that he abandoned his "patient."

One's first reaction is "why"? This man fully met his moral obligation; the woman had no severe injuries, in fact she probably caused the complications herself by neglecting to follow the advice to go to the hospital. It is understandable that the physician in this situation was irate. What social purpose does the law serve when it imposes civil liability on this doctor? No one in good conscience could ask this man to do more — but the law does. Small wonder that many physicians react adversely to "shyster lawyers." The proposal presented by this writing solves this problem because it imposes no duty of a continued relationship, and it requires only that the physician meet the standard of reasonable *first aid* care.

Conclusion

Many oppose any form of immunity legislation. They believe, and rightly so, that doctors should be as responsible for misconduct as anyone else. Yet some statutory reform is obviously needed. The realities of accident-scene treatment must be recognized. Adequate, much less thorough, diagnosis is often impossible. The law should recognize these realities in an affirmative manner. The nebulous standard of "reasonable care" is not the answer nor is a grant of complete immunity.

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