William & Mary Law Review

Volume *10 (1968-1969)*
Issue 4

Article 10

May 1969

Emergency Medical Treatment

Earle T. Hale

EMERGENCY MEDICAL TREATMENT

INTRODUCTION

Of all the arts known to man medicine has long been revered as one of the most noble. It is indeed a tragic commentary on the state of the profession, in light of the vast scientific advances in the healing arts and the almost unbelievable manipulative surgical techniques of today's surgeons, that rather than the patient and the physician being drawn closer together, a wedge of fear and distrust has been driven firmly between them.[1]

A startling manifestation of this distrust appeared in an issue of the Insurance Law Journal where the author, concluding his remarks concerning the almost unbelievable rise in the number of medical malpractice cases, stated:

> In lecturing to M.D.'s, I have always emphasized the need for mutual cooperation on the theory if the M.D.'s do not hang together they will most assuredly hang separately. Evidently we must broaden that warning into if all aspects of the medical profession do not hang together they will most assuredly hang separately.[2]

With this as a point of departure, it will be the intent of this discussion to examine the relationship between physician and patient as it exists today with particular emphasis on the legal complexities arising out of medical treatment rendered at the scene of an emergency.

HISTORICAL BACKGROUND OF MALPRACTICE

The first reported case of a physician being brought to bar for malpractice appeared in the latter part of the twelfth century when a sur-

1. Between the years 1935 and 1955 there were 605 reported cases of medical professional liability in the United States. Sandor, *The History of Professional Liability Suits in the United States*, 163 J.A.M.A. 459 (1956).

In the year 1959, six thousand physicians were sued for medical malpractice. Crawford, *Malpractice: Medical—The Important Events of the Last Two Years*, 30 INS. COUN. J. 44, 67 (1963).

"A recent survey indicates that there are over 5,000 malpractice cases being tried each year and that thousands each year are being settled out of court." Stewart, Bradford, & Kelly, *Medical Malpractice*, 27 INS. COUN. J. 621, 622 (1960) [hereinafter cited as Stewart].

2. Crawford, *supra* note 1, at 67.

geon undertook to treat an injured hand, and allegedly treated it so negligently that he maimed the patient.[3] While the plaintiff's suit was dismissed, the court did indicate that it felt the surgeon had acted with all due diligence and had performed as well as *he was able.* This development in the law suggested that the early English courts were unwilling to require the application of any external or objective standards of care in measuring a physician's professional performance.

As the law of malpractice developed, the English courts began to recognize the need for a rule of law that would establish some external standard against which the physician's skills could be measured. Finally, they arrived at a rule of law that would hold the physician liable when he assumed to undertake the care of a patient and performed deficiently either through ignorance or lack of skill.

In America, a 1794 Connecticut case[4] was the first in which the professional liability of a physician was at question. The complaint alleged that the physician had performed an operation in an ignorant and unskillful manner and the cause was held to be sufficient in law. Some sixty years later a Pennsylvania court,[5] discussing the physician-defendant's mode of treatment, stated that "the question was not whether the doctor had brought to the case skill enough to make the (patient's) leg as straight and as long as the other, but whether he had employed such reasonable skill and diligence, as [was] ordinarly exercised in the profession." [6]

With the development of contract law, the American courts became aware that the physicians' services were often rendered pursuant to a contract, and, increasingly, began to express liability in contractual terms. The measure of skill and care which the law required of the physician was not at all changed by basing a cause of action for the physician's liability in breach of implied contract for failure to possess and exercise the requisite skill and care. This contractual cause coupled with the earlier action resulting from the physician's failure to exhibit the necessary knowledge or demonstrate the requisite skill, when he assumed an undertaking, merely allowed two distinct actions under which the physician could be held liable.

Today the actions are unchanged even though the "law of medicine" has been refined. The physician is not considered to be a "warrantor of

3. G. DRIVER & J. MILES, THE BABYLONIAN LAWS 81 (1955).
4. Cross v. Guthery, 2 Root 90; (1794).
5. McCandless v. McWha, 22 Pa. 261 (1853).
6. *Id.* at 267-68.

cures." [7] He is held only to that standard of medical skill and knowledge commonly practiced and possessed by members of the same or similar community, and that degree of care and skill ordinarily exercised by those physicians in the application of their skill, or the unique skill of the specialist, if the physician represented himself as possessing it.[8]

The physician, although liable for his acts and omissions once he undertakes the treatment of a patient, is under no positive duty or obligation to accept for treatment all who apply to him. He has the right to refuse to render medical treatment without regard to the needs of the patient. This right of refusal was first granted in the landmark case of *Hurley v. Eddingfield*.[9] There, the defendant-physician had established himself as a general practitioner of medicine in the community and had been decedent's family physician for some time. The decedent, after becoming dangerously ill, sent for the physician. The decedent's wife informed the doctor of her husband's violent sickness, and offered him his fee for his services. She explained to him that no other physician would be available in time, and that they relied heavily on him for medical attention. "*Without any reason whatever, [the physician] refused to render aid to decedent. No other patients were requiring [the physician's] immediate service, and he could have gone to the relief of decedent if he had been willing to do so. Death insued. . . .*" [10] The physician was held not liable. The actions of the physician in this case are discomforting at best and appear to be in direct conflict with the "Principles of Medical Ethics" of the American Medical Association. These "principles," however, have no binding effect on the physician.

It must be recognized that malpractice law was developed in relatively few cases, simply because of the sparsity of litigation. But as the prac-

7. Ewing v. Goode, 78 F. 442 (C.C.S.D. Ohio 1897); Sim v. Weeks, 7 Cal. App. 2d 28, 45 P.2d 350 (Dist. Ct. App. 1935)

8. D. LOUISELL & H. WILLIAMS, TRIAL OF MEDICAL MALPRACTICE SUITS 200-02 (1968) [hereinafter cited as LOUISELL].

9. 156 Ind. 416, 59 N.E. 1058 (1901). *See, e.g.*, Rayburn v. Day, 126 Ore. 135, 268 P. 1002 (1928); Rann v. Twitchell, 82 Vt. 79, 71 A. 1045 (1909).

It is interesting to note that §5 of the American Medical Association's *Principles of Medical Ethics* rejects this, although in practice the profession clings tenaciously to it.

> §5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

10. *Supra* note 8, (emphasis added).

tice of medicine moved in the direction of an impersonal business and left behind the warm personal relationship that had existed between the physician and his patient, the medical malpractice suit became more prevalent.[11]

There can be no question that both the quantity and quality of medicine practiced today is vastly superior to that of thirty years ago. Today, however, it is forced to stand alone in a community whose constant mobility prevents the formation of strong personal relationships between patient and physician, and whose better educated members have become increasingly inquisitive and critical of the physician with whom they enter so personal a relationship.

While the discovery of a single definitive answer to the spectacular rise in malpractice actions is remote, it is clear that the absence of any genuine rapport between physician and patient is a singularly important factor.[12] Achieving that rapport is then of great import to bringing some stability to the current practice of medicine.

---

11. Steward, *supra* note 1. *See, Breakdown in Doctor-Patient Relationships Shown by Malpractice; Suits Say Psychologists in C.M.A. Study*, BULL. OF THE AM. COLL. OF SURGEONS, May-June 1959, 3.

12. One of the leading causes of malpractice suits is the absence of rapport between doctor and patient. That the patient feels strongly on this score is reflected in a poll conducted by the American Medical Association a few years ago. Patients complained that doctors:

> 60%—do not give patients enough time
> 54%—hide mistakes for other doctors
> 51%—are hard to find in an emergency
> 43%—charge too much
> 39%—do not show enough personal interest
> 31%—are too quick to perform surgery
>
> A group of psychologists who conducted a study of the origins of malpractice suits concluded that: The growing malpractice problem is primarily a human relations problem and required human relations research . . . . [S]uits are drastic symptoms of a breakdown in the relationship between the doctor and his patient . . . . [T]he origins of malpractice suits depend more upon how the patient feels about the doctor and how the doctor acts toward the patient . . . . In order to prevent claims from originating they recommended: development of standards of conduct for physicians in hospitals, so physicians will not feel the painful reluctance they do now in calling attention to substandard practices of a colleague.

Goldman, *Are Doctors Ignoring the Law?* TRIAL, June-July, 1965, at 19, 21. (footnotes omitted) [hereinafter cited as *Goldman*]. *See generally* LOUISELL, *supra* note 8, at 137-38.

Lending some credence to this theory, in a recent issue of the Wall Street Journal Dr. Milford O. Rouse, past president of the A.M.A., was quoted as having warned an A.M.A. meeting: "We are faced with the concept of health care as a right rather than as a privilege." The Wall Street Journal, Feb. 7, 1969, 1.

The Malpractice Suit Per Se

It must be clearly understood that it is not the successful malpractice suit the physician fears, but rather the very threat of a malpractice suit.[13] The individual physician believes that regardless of its outcome, the commencement of a single malpractice suit is enough to do irreparable harm to his professional standing, by branding him professionally incompetent or worse, and cause him serious financial reverses due to a decreased practice.[14] The physician is acutely aware that even if he wins his law suit he often loses a great deal.

In attempting to ameliorate the hazards of a malpractice suit, the physician has assumed a defensive posture that he feels will aid in protecting him from such action. In many cases he may be extremely reluctant to accept an unknown patient for fear that he may be exposing himself to an unknown quantity of questionable temperament.[15] He will in all cases attempt to screen new patients carefully, and maintain the

13. Comment, *Wisconsin's Good Samaritan Statutes*, 48 MARQ. L. REV. 80, 82 (1964).

14. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 609 (1959).

Apparently the effects of a malpractice action upon the physician's practice are grossly exaggerated. In a fairly recent survey of some fifty-eight physicians against whom malpractice actions had been brought, an article in the J.A.M.A. concluded:

> Objectively, the effects of a malpractice suit upon a physician appear to be much less than generally believed. Not one case was found of a physician compelled to give up his practice and move, no physicians lost their licenses, none were rejected from hospital privileges, staffs, or societies; none were unable to obtain malpractice insurance though a handful had to switch companies and pay higher rates; none claimed to have suffered professionally and none suffered socially. Wychoff, *The Effects of a Malpractice Suit Upon Physicians in Connecticut*, 176 J.A.M.A. 1096, 1101 (1961).

Five of the physicians actually noted an increase in their practice and only one stated that he was temporarily injured by the suit. *See, How State Medical Society Executives Size Up Professional Liability*, 164 J.A.M.A. 580, 582 (1957). This article concludes that malpractice claims do not have a "serious or extended effect" on the physician or his practice.

15. McCoid, *supra* note 14, at 608. *See also* the statement of an anonymous physician reported in Silverman, *Medicine's Legal Nightmare, Part One*, SATURDAY EVENING POST, April 11, 1959, at 13, 48:

> Now, whenever a new patient comes into my office, I ask myself, "Is this the fellow who's going to sue me?" and, God help me, I'm beginning to decide my treatments not on the basis of what's best for the patient, but on what will look best in court.
>
> This article also points to the increased cost of medical care in terms of additional consultations and diagnostic procedures which doctors may feel compelled to undertake not for the benefit of the patient but for their own legal protection.

proper psychological distance to restrict initial familiarity. The doctor may be most hesitant to employ new medical techniques for fear he may be subject to the charge of failing to exercise due care or, even worse, of experimentation.[16] This reaction can, of course, only serve to the detriment of a patient in need of imaginative and bold treatment to effect a cure.

Conspiracy of Silence

The concern for the state of the medical profession is not of recent vintage. The Code of Hammurabi of 1750 B.C. provided for *inter alia*, having an erring physician's hand cut off.[17] Later societies, apparently faced with a shortage of sufficiently intrepid men to treat their ills turned to a less drastic form of censure for malpractice, the financial judgment.

The physician, with extraordinary skill and care, has banded his numbers together into a tightly knit professional fraternity of common interests and goals. In accomplishing this the medical profession has secured to itself an immunity from prosecution for professional negligence that is virtually unassailable. The "conspiracy of silence" is the tool with which this immunity has been fashioned.[18]

The requirement that a patient produce independent expert medical testimony to establish the proper standard of care[19] and the defendant-physician's failure to meet that standard, imposes an almost insurmountable obstacle to the aggrieved plaintiff. Without the benefit of such expert medical testimony the jury may not be competent to judge the defendant's conduct, and a directed verdict will be entered for the defendant-physician. Despite the indispensibility of such testimony there has been a traditional reluctance among physicians to testify against their fellows.[20] This has been denominated a "conspiracy of silence." [21]

16. *See generally* L. Regan, Doctor and Patient and the Law 65 (1965).

17. *Id.* at 370-72.

18. *See* Bryan, *Good Samaritan Law—Good or Bad?*, 15 Mercer L. Rev. 477 (1964); Note, *Overcoming the Conspiracy of Silence: Statutory and Common Law Innovations*, 45 Minn. L. Rev. 1019 (1961). *See also* Edwards v. West Texas Hosp., 89 S.W.2d 801 (Tex. Civ. App. 1935).

19. *See* Note, *Medical Malpractice—Expert Testimony*, 60 Nw. U.L. Rev. 834 (1966).

20. Anyone familiar with cases of this character knows that the so-called ethical practitioner will not testify on behalf of a plaintiff regardless of the merits of his case. . . . But regardless of the merits of the plaintiff's case, physicians who are members of medical societies flock to the defense of their fellow members charged with malpractice and the plaintiff is

It has been argued that mere reluctance to testify does not establish a "conspiracy of silence" in any precise sense of the word "conspiracy," but where the reluctance has been so wide-spread and notorious the criteria of the definition have been amply met. This "conspiracy" has been acknowledged, as a matter of judicial notice, by courts in several jurisdictions.[22]

In the past twenty years it has become evident that the loyalty which motivated this "conspiracy of silence" has served to create more problems than it has solved, much to the detriment of the entire profession. Many jurisdictions reacted to this extra burden placed upon the plaintiff by widening the scope of the law and extending legal doctrines to more

relegated, for his expert testimony, to the occasional lone wolf or heroic soul, who for the sake of truth and justice has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy. Huffman v. Lindquist, 37 Cal.2d 465, 484, 234 P.2d 34, 46 (1951).

But gradually the courts awoke to the so-called "conspiracy of silence." No matter how lacking in skill or how negligent the medical man might be, it was almost impossible to get other medical men to testify adversely to him in litigation based on his alleged negligence. Not only would the guilty person thereby escape from civil liability for the wrong he had done, but his professional colleagues would take no steps to insure that the same results would not again occur at his hands. Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 568, 317 P.2d 170, 175 (1957).

This court recognizes that it is difficult to obtain medical testimony to substantiate a plaintiff's claim in a malpractice suit, as physicians are reluctant to testify against each other. Richison v. Nunn, 54 Wash.2d 371, 340 P.2d 793, 802-03 (1959).

21. *See* Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250, 259 (1956).

22. Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957); *accord*, *supra* note 20; *see* Bernstein v. Alameda-Contra Costa Medical Ass'n, 139 Cal. App. 2d 241, 293 P.2d 862 (1956). Petitioner-physician was expelled from his local medical society because of a report he had written for a plaintiff characterizing a fellow physician as "inept and inexpert." In Boswell v. Board of Medical Examiners, 72 Nev. 20, 293 P.2d 424 (1956), the court enjoined the Board proceedings to revoke the physician's license because of caustic comments made about other physicians. In Virgin v. American College of Surgeons, 42 Ill. App. 2d 352, 192 N.E.2d 414 (1963), there is some indication that his involvement in a plaintiff's malpractice case was a prime factor in the physician's expulsion from the American College of Surgeons. In Reynolds v. Struble, 128 Cal. App. 716, 731, 18 P.2d 690, 696 (1933), "It was shown that some of the medical witnesses had approached the plaintiff's witness and attempted to intimidate him or at least dissuade him from testifying under pain of ostracism." *See also* Glückstien v. Lipsett, 93 Cal. App. 2d 391, 405, 209 P.2d 98, 112 (1949). *See generally*, Note, *Malpractice and Medical Testimony*, 77 HARV. L. REV. 333 (1963); Note, *Judicial Annulment of Expulsions From Private Associations*, 60 NW. U.L. REV. 241 (1965).

finely adjust the scales of justice.[23] This trend has been noted by the medical profession with some degree of alarm, and recently the California Medical Association has been active in attempting to reverse the trend.[24] Reversing the trend, however, without affording the genuinely aggrieved plaintiff access to competent medical authority can only result in injustice and a further derogation of the physician-patient relationship. It would be far better to remove the need for the "conspiracy of silence."[25]

---

23. *See Medico-Legal Boomerang: Conspiracy of Silence*, TRIAL, Oct.-Nov., 1966, at 15. One significant example is the extension of the doctrine of *res ipsa loquitur*. This doctrine was first applied in Byrne v. Boadle, 159 Eng. Rep. 299 (Ex. 1863).

In instances where the plaintiff is unable to obtain favorable expert medical testimony the application of the doctrine becomes essential. The application of the doctrine is limited by certain well settled principles. The event involved:

> 1) must be of a kind which ordinarily does not occur in the absence of someone's negligence;
>
> 2) must not be caused by an instrumentality or agency within the exclusive control of the dependent;
>
> 3) must not have been due to any voluntary action or contribution on the part of the plaintiff. *Supra* note 8, at 425.

It is still held in a majority of the states that the doctrine does not apply where common knowledge or experience is not sufficiently extensive to permit it to be said that the patient's condition would not have existed but for the negligence of the doctors. Ayers v. Parry, 192 F.2d 181, 185 (3d Cir. 1951). A further example of the extention of the doctrine can be seen in Fehrman v. Smirl, 20 Wis. 2d 1, 121 N.W.2d 255 (1963). There the Supreme Court of Wisconsin stated that the question of negligence in the case "did not lie within the field of common knowledge of layman," but went on to hold that a *res ipsa loquitur* instruction to the jury could be supported on the basis of expert medical testimony given into evidence at the trial. *See generally* Note, *The Application of Res Ipsa Loquitur in Medical Malpractice Cases*, 60 NW. U.L. REV. 852 (1966).

24. Sheridan, *How M.D.'s Are Winning Malpractice Relief*, MEDICAL ECONOMICS, Sept. 16, 1968 at 21.

25. It is in the interest of the medical profession and the patients that doctors should act boldly and acknowledge their errors, and not ignore a fellow physician's negligence. In the *Cleveland-Marshall Law Review*, May, 1959, Dr. Miley B. Wesson advised physicians to never admit that the author of a textbook was an authority on the subject when they were defending themselves in a malpractice case. In my view, this was an open invitation to doctors to lie their way out of liability; the medical profession should openly disavow such conduct. . . .

> We might well paraphrase the words of the late Justice Cardozo, when he commented on the power of the courts to clean house in the legal profession:
>
> In the long run the power now conceded will make for the health and honor of the profession and for the protection of the public. If the house is to be cleaned, it is for those who occupy and govern it, rather than for strangers, to do the noisome work. Goldman, *supra* note 12, at 21.

The physician is painfully aware that he is not infallible. He and the other members of the medical profession must recognize that when a fellow practitioner has caused harm through a negligent act he must be held responsible as must any other member of the society. Failing to do this, and with specific reference to the extraordinary rise in medical malpractice litigation and the apparent public attitude of increasing disenchantment, can only serve to precipitate legislation and further judicial decision that will clearly reflect this disenchantment to the overall detriment of the medical profession. The effort must be joint, for it is extremely unlikely that the individual physician will be willing to act except in unison with other members of the profession.

A Possible Solution

New Jersey's supreme court has sought to solve the problem for the benefit of both physician and patient by setting forth rule 4:25B which attempts to discourage the filing of baseless professional liability claims and to make expert medical testimony available to plaintiffs when it is clear that there is a reasonable basis for the claim. The following is an outline of this procedure.

(1) The administrative director of the courts maintains a register of physicians designated by the state of New Jersey Medical Society and a register of attorneys designated by the supreme court from which he is able to form as many subpanels as may be required at any one time.

(2) All of the litigants to a malpractice claim are urged to submit their cases voluntarily and informally to a subpanel of two doctors, two lawyers and a former justice of the supreme court or former judge of the superior or county court, who acts as chairman of the subpanel and votes only in case of a tie, for evaluation, preferably before litigation is instituted.

(3) The director notifies the defendant of the existence of the claim and requests that he consent to the informal hearing after consulting as to the advisability of such action with his own attorney and insurance carrier.

(4) The hearing is then held informally behind closed doors before the subpanel with only the parties and their attorneys present.

(5) The plaintiff's claim is then presented either orally or in written form, and the claimant and his witnesses may then be questioned by the physician's attorney, if the claimant consents.

(6) The physician then presents his side of the case, his witnesses do the same, and they are likewise subject to questioning by the attorney for claimant, if they agree to such questioning.

(7) The subpanel then considers the evidence presented and brings in one of two findings: (a) that there is a reasonable basis for the claim; or (b) that there is no reasonable basis for the claim. No opinion is given as to the extent of the damages sustained.

(8) If the finding of the panel is unfavorable to the claimant, it recommends that no suit be filed against the physician or, if one has been filed, that it be discontinued.

(9) If the finding of the subpanel is favorable to the claimant, the subpanel recommends that the claim be amicably and expeditiously settled.

(10) At the commencement of the informal proceeding the claimant is requested to consent in writing that, if the subpanel disagrees with his contention, he will not institute suit, or if one is pending, he will discontinue it.

(11) If the claimant signs this agreement and the subpanel decides that he has a reasonable basis for his claim (and no settlement is effected), the director agrees to supply the names of three expert medical witnesses from a list compiled by the New Jersey Medical Society, any or all of whom *will* serve as witnesses.

(12) The counsel for the claimant is required, if the subpanel finds no reasonable basis for the claim, not to institute a suit based thereon, and if one is *pending* in which he appears as counsel, he must withdraw. The claimant, however, is free to retain other counsel to continue the suit or institute one if no agreement to the contrary has been signed.

(13) All proceedings are strictly confidential and absolutely no record is made of the proceedings. If medical experts have been made available to the claimant because the claim has not been settled, the manner in which the expert witnesses were made available to the claimant is not disclosed to anyone.

This procedure ensures a fair and equitable hearing for all of the parties concerned, and effectively serves to eliminate the "conspiracy of silence, thereby affording a remedy to the genuinely aggrieved patient and protection to the unfairly accused physician." [26]

26. N.J. Sup. Ct. R. 4:25B—Professional Liability Claims Against Members of the Medical Profession; Procedure.

GOOD SAMARITAN STATUTES

In 1959, California passed the Medical Practice Act, euphemistically known as the Good Samaritan Statute, and since that time thirty-seven other states have enacted similar legislation.[27] The statutes generally provide that no physician who in good faith renders emergency care at the scene of an emergency shall be liable for civil damages resulting from either acts or omissions, barring, of course, gross negligence.

The public, the legislatures, and the state medical associations had all hoped that such statutes would encourage physicians to render emergency treatment when called upon. The opposite was true, however, for a careful examination of the statutes reveals that they do not at all protect the physician from a malpractice action, and the physician was quick to sense this.

What they do accomplish, however, is to provide the physician with an excellent defense to a malpractice action if one is instituted against him. The need for such legislation is even more dubious when viewed in light of an article in the *New England Journal of Medicine*. There the author concluded:

> The first problem with these laws is in assessing the public need for them. Are doctors being sued who render emergency aid? There is not a single case of such a suit to have reached the appellate level of any jurisdiction in this country. Also, there is no information of any trial-court cases in the United States. (One action involving a Massachusetts physician has been reported in

27. ALASKA STAT. tit. 8, § 08.64.365; ALA. ACTS, art. 253 (Supp. 1967); ARK. STAT. ANN. § 72-624 (Supp. 1967); CAL. BUS. & PROF. CODE § 2144 (Supp. 1960); CONN. GEN. STAT. ANN. § 52-557b (Supp. 1967); DEL. CODE ch. 17, tit. 24, § 1767 (Supp. 1966); D.C. CODE, tit. 2, § 142 (Supp. 1968); FLA. STAT. § 768.13 (Supp. 1967); GA. CODE ANN. § 84-930 (Supp. 1968); IDAHO CODE § 5-330 (Supp. 1968); ILL. ANN. CODE, ch. 91, § 2a (Supp. 1969); IND. ANN. STAT. § 63-1361 (Supp. 1968); KAN. STAT. ANN. § 65-2891 (Supp. 1968); LA. REV. STAT. § 37:1731; MASS. GEN. LAWS ANN., ch. 112, § 12B (Supp. 1969); MICH. STAT. ANN. § 14.563 (Supp. 1969); ME. REV. STAT. ANN., tit. 32, § 3151; MD. ANN. CODE, art. 43 § 149 A; MISS. CODE ANN., § 8893.5 (Supp. 1966); MONT. REV. CODES ANN. § 17-410; NEB. REV. STAT. § 25-1152; NEV. REV. STAT. § 41.500 (Supp. 1963); N.H. REV. STAT. ANN. § 329.25; N.J. STAT. ANN. § 2A:62A-1 (Supp. 1969); N.M. STAT. ANN. § 12-12-3 (Supp. 1967); N.Y. EDUC. LAW § 6513 (10) (Supp. 1969); N.D. CENT. CODE § 43-17.37 (Supp. 1967); OHIO REV. CODE ANN. § 2305.23 (Supp. 1968); OKLA. STAT. ANN., tit. 76, § 5 (Supp. 1969); PA. STAT. ANN., tit. 12, §§ 1641, 1642 (Supp. 1969); R.I. GEN. LAWS ANN. § 5-37-14 (Supp. 1968); S.C. CODE, tit. 46, § 803 (Supp. 1968); S.D. SESSION LAWS 1961, ch. 137; TENN. CODE ANN. § 63-622 (Supp. 1968); TEX. CIV. STAT. ANN., art. 1a (Supp. 1968); VA. CODE ANN. 54-276.9 (Supp. 1968); WIS. STAT. ANN. 147.17(7) (Supp. 1969); WYO. STAT. ANN. § 33-343.1 (Supp. 1967).

> the Virgin Islands.) There are no published statistics on insurance claims to indicate this is an area of significant risk. Governor Kerner of Illinois vetoed such a bill in August, 1963,[28] and said "so far as I can ascertain, the attendant danger (of malpractice suits) is largely, if not wholly imagined. A systematic inquiry into all the reported malpractice decisions has failed to disclose a single roadside instance." [29]

An examination of the Good Samaritan Statutes reveals that there are several problems indigenous to them. First, there is a great diversity among the statutes regarding exactly *who* is to be relieved of civil liability. Second, many of the statutes require that emergency medical care must have been rendered gratuitously before immunity from civil liability attaches, although some of the statutes fail even to provide a clearcut definition of gratuitous aid. Third, most of the acts are applicable only where an "emergency" exists, but fail to define what constitutes an "emergency." Fourth, the statutes are vague in defining the exact degree of misconduct that will be immune from civil action. Fifth, other statutes could be mistakably interpreted as failing to provide protection from a possible cause of action for abandonment against a medical person who ceases to care for an emergency patient when the patient is delivered to other competent medical personnel.[30]

Faced with an emergency situation, the doctor is shorn of all of his protective devices. The customary caution that he normally exercises is precluded by the sudden and extreme demands of the moment. The quality and quantity of the medical treatment he renders must of necessity be derogated by the absence of adequate facilities and equipment. These deficiencies and dangers coupled with the relative inefficacy of the statutes in protecting the physician from the commencement of the malpractice suit defeat the very purpose of their passage. The physician's fears of his liability in rendering aid in an emergency situation are excessive and irrational; but unless these fears are laid to rest the physician will be unlikely to assume a burden of liability he feels weighing heavily upon him. The Good Samaritan Statute, clearly, does nothing to allay these fears.

28. Illinois has subsequently passed a Good Samaritan Statute, *supra* note 27.

29. 270 THE NEW ENGLAND J. OF MEDICINE, May 7, 1964, at 1003. *See* letter on file WILLIAM AND MARY LAW REVIEW from George E. Hall, Legal Division, American Medical Association, to the author, August 14, 1968, attesting to the fact that there have been no cases of this nature.

30. Note, *Negligence-Medical Malpractice-Criticism of Existing Good Samaritan Statutes*, 42 ORE. L. REV. 328, 330 (1963).

IMPOSITION OF A POSITIVE DUTY

Going beyond the mere granting of an immunity as suggested by the Good Samaritan Statute, and forcing a physician to perform against his will in an emergency situation through the legislative enactment of a statute, it has been argued, would violate his rights to due process under the fourteenth amendment, and subject him to involuntary servitude prohibited by the thirteenth amendment. The power of the state, however, over the medical profession has long been recognized as absolute.[31]

A similar argument has been raised by members of the legal profession appointed to defend the accused in a criminal proceeding. In these cases the specific question litigated was whether the attorney should be compensated for his services in the absence of a statutory provision. The majority view supported the proposition that, in the absence of a controlling statute providing for compensation, an attorney assigned a case may not recover compensation from the state.[32]

The majority rule states that the courts do have the power to compel an attorney to represent an indigent in a criminal proceeding without compensation absent statutory authority. Even those jurisdictions which adhere to the minority rule requiring compensation do not hold that an attorney can refuse to accept his appointment. It is universally held that an attorney is an officer of the court and may not refuse to serve save for good and proper reasons.

Those jurisdictions which require an attorney to render his services gratuitously in criminal cases adhere to one of the two following rationales. First, "The duty of gratuitous service is correlative to the special rights and privileges which have been conferred upon the attor-

31. Lambert v. Yellowley, 272 U.S. 581 (1926), (". . . [t]here is no right to practice medicine which is not subordinate to the police power of the States. . . ."); Dent v. West Virginia, 129 U.S. 114 (1889).

32. *See* Pound, *What is a Profession?*, 19 NOTRE DAME LAWYER 203 (1944); M. PIRSIG, JUDICIAL ADMINISTRATION, 810-22 (1946).

In People *ex rel.* Karlin v. Culkin [248 N.Y. 465, 162 N.E. 487 (1928)] Judge Cardozo said:

> Membership is a privilege burdened with conditions. . . . The appellant was received into that ancient fellowship for something more than private gain. He became officer of the court, and, like the court itself, an instrument or agency to advance the ends of justice. *Id.* at 470-71, 162 N.E. at 489. (footnotes omitted).

See also King & Sears, *The Ethical Aspects of Compromise, Settlement and Arbitration*, 25 ROCKY MT. L. REV. 490, 492 (1953). The AM. MEDICAL ASS'N'S PRINCIPLES OF MEDICAL ETHICS § 1 states: "The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man."

ney;" [33] and second, that the state's power to license includes the power to impose such obligations upon the attorney.

It is appropriate to wonder what distinction there is between requiring an attorney to protect a man's life in a criminal court, and in requiring a physician to preserve a life in an emergency situation. Is it not logical that if the attorney, as the only one capable of protecting life and liberty in the courts is required to serve when called upon, that the physician as the only one capable of preserving life in an emergency situation, should be required to serve when and where the need arises? The duty of service is no less "correlative to the special rights and privileges which have been conferred upon the" [34] physician.

The attorney is bound by canons of legal ethics which, if violated, subject him to disbarrment and the attendant loss of his license to practice law.[35] Contra to a popular belief, the physician is not required to take the oath of Hippocrates. It is purely ceremonial in nature and has no legal efficacy. The Principles of Medical Ethics of the American Medical Association also have no legal efficacy and are merely a suggested framework upon which the physician can construct his own mode of behavior. It thus appears that human sympathy and a just sense of professional obligation are the only motivations available to move the physician to the aid of his fellow man in distress.

Statutory Imposition of Duty to Act

At common law there was no positive duty created where one person was required to render aid to another in an emergency situation, unless that person was responsible for the creation of the situation.[36] The courts soon recognized, however, a few areas where the imposition of such a duty was clearly in the public interest. Examples of such relationships were those of department store and invitee,[37] public carrier and passenger,[38] and master and servant.[39]

33. Nabb v. United States, 1 Ct. Cl. 173 (1864); Ruckenbrod v. Mullins, 102 Utah 548, 133 P.2d 325, 327 (1943); Presby v. Klickitat County, 5 Wash. 329, 31 P. 876 (1892).

34. Ruckenbrod v. Mullins, 102 Utah 548, 133 P.2d 325, 327.

35. Matter of Rouss, 221 N.Y. 81, 116 N.E. 783; People v. Culkin, 248 N.Y. 465, 162 N.E. 487.

36. W. Prosser, Law of Torts 334 (3d. ed. 1964).

37. *See* L. S. Ayres & Co. v. Hicks, 220 Ind. 86, 40 N.E.2d 334 (1942).

38. *See* Birmingham Ry., L. & P. Co. v. Glenn, 179 Ala. 263, 60 So. III (1912). *See generally supra* note 36, at 45.

39. *See* Hunicke v. Meramec Quarry Co., 262 Mo. 560, 172 S.W. 43 (1914); Szabo v. Pennsylvania R.R., 132 N.J.L. 331, 40 A.2d 562 (1945).

As the state of the law progressed, there became discernible a demonstrable willingness to create liability for failure to act out of purely moral considerations. The duties arising from the relationship between parent and child provide a good example. The common law obligations of parents or guardians to support and care for children of tender age or infirmity has now, in many instances, become firmly based in statutory acknowledgment.[40] The further we move from the familial relationship, however, the uniting bond becomes weaker and the common law duty to act becomes more problematical. Statutes creating liability for omissions in the interest of the public health and welfare are not uncommon. For example, under federal statute the master of a vessel, where there is no "serious danger" to his own ship, crew or passengers, is under a positive duty to render assistance to "every person who is found at sea in danger of being lost." [41]

Closer to the issue of the medical profession's responsibility, physicians in many states are required to report all cases in which it is likely that injuries suffered by a child have been caused by parental abuse.[42] In many jurisdictions there is a positive duty placed upon the physician to report all gunshot and knife wounds to the police.[43] Any omission, regarding these positive duties to act, will subject the erring physician to the established statutory penalty. Thus it is clear that the states have

40. *E.g.*, Lewis v. State, 72 Ga. 164 (1883); People v. Pierson, 176 N.Y. 201, 68 N.E. 243 (1903); *See also* Mitchell v. State, 39 Ga. App. 100, 146 S.E. 333 (1929); Children & Young Person's Act of 1933, 23 Geo. 5, c. 12, §1.

41. Duty of master to assist persons in danger. The master or person in charge of a vessel shall, so far as he can do so without serious danger to his own vessel, crew, or passengers, render assistance to every person who is found at sea in danger of being lost; and if he fails to do so, he shall, upon conviction, be liable to a penalty of not exceeding $1,000 or imprisonment for a term not exceeding two years or both. 46 U.S.C. § 728 (1964).

42. *See, e.g.*, ARIZ. REV. STAT. ANN. § 13-842.01 (Supp. 1964); FLA. STAT. ANN. § 828.041 (Supp. 1963); N.Y. SOCIAL SERVICES LAW § 383-f.

43. *See, e.g.*, NEW YORK PENAL LAW OF 1968 § 265.25 Reports of treatment of wounds caused by firearms. 1. Every physician attending or treating a case of bullet wound, gunshot wound, powder burn, or any other injury arising from or caused by the discharge of a gun, pistol, or other firearm, or whenever such case is treated in a hospital, sanitarium or other institution, the manager, superintendent or other person in charge shall report such case at once to the police authorities of the city, town or village where such physician, hospital, sanitarium or institution is located. The provisions of the section shall not apply to such wounds, burns or injuries received by a member of the armed forces of the United States or the state of New York while engaged in the actual performance of duty. 2. Failure to make such report shall be a misdemeanor.

not been hesitant to act to impose affirmative obligations upon physicians when the public health and welfare have been threatened.

It is, of course, most desirable that a man should go beyond merely abstaining from doing his neighbor violence, and should instead take an active interest in his welfare. Today our penal laws content themselves with restraining men from the commission of overt socially undesirable acts, and leave to the public conscience and the religious community the responsibility of motivating men in the direction of positive good. Relative impunity is granted to those whose omissions a righteous man would brand as reprehensible, and punishment is reserved for those whose omissions have been marked as the particularly proper objects of penal legislation.

The question of imposing a positive duty to act must turn on whether the freedom to remain inactive to the detriment of one's neighbor serves ends that are sufficiently desirable to the society to compensate for the evil that such inaction permits to occur. The weight of such a burden on the individual is a particularly relevant factor in making such an evaluation, and where the burden is light, the requirement for liability for misfeasance is strong. The difficulties involved, therefore, in forming new socially desirable requirements are no more insurmountable than in the case of forbidding undesirable acts.

A European Solution

It is indeed an extraordinary dichotomy that a nation that prides itself on its humanity and the sophistication of its judicial system should lag so pitifully behind other nations in acting for the protection of its citizens, by failing to impose a positive duty upon its physicians to render emergency aid to those injured and in need of immediate medical attention. In modern America this need for legislative action is ever-growing and the consequences of the failure to act are tragically accentuated each year. In a recent study of the economics of personal injury it was noted:

> . . . [F]or its increasing mobility, spreading cities, and booming technology, modern society pays a fearful price in accidental injuries. Each year accidents claim 10,000,000 victims, of whom 100,000 are fatalities. In a nation of 180,000,000 people this means that over 5% of the population annually become accident statistics.

> Pale before the human cost, but staggering in its own right, is the economic price of accidents. Evidence for recent years suggests that lost wages and medical expenses alone amount to almost $5,000,000,000. In addition, there are other, more indirect consequences, and the total economic cost of accidents may well exceed $15,000,000,000.[44]

Clearly this nation cannot afford, from the standpoint of economics alone, to allow a practice to continue which contributes to the perpetuation of this staggering loss. When viewed from the humane point of view, the thought must arise as to how many lives might have been saved had a positive duty been imposed upon physicians to act in emergency situations.[45] Requiring the physician to act in an emergency situation is not the solution to the entire problem of reducing the toll taken by accidental injury, but it is a beginning in the development of such an overall solution that can only serve to ameliorate the present trend.

The needs of the public in a dynamic and ever-changing society demand a new evaluation of what the law ought to be. Today it is required of a society that has just passed the 200 million mark to determine if we are to be the keepers of our brothers' lives.

In Europe this question has been answered in the affirmative. The criminal codes of Denmark, Italy, Poland, Portugal, Rumania, and Turkey establish criminal liability for *anyone* who refuses to aid persons "in peril" or "in danger of death."[46] Belgium,[47] France,[48] Germany,[49] Holland,[50] and the Soviet Union[51] have also statutorily imposed criminal liability on *all* who fail to act in an emergency situation.

44. Franklin, Chanin & Mark, *Accidents, Money, and the Law: A Study of the Economics of Personal Injury Litigation*, in W. MEYER, DOLLARS, DELAY AND THE AUTOMOBILE VICTIM 70-71 (1968).

45. *See* Note, *Good Samaritan and Liability for Medical Malpractice*, 64 COLUM. L. REV. 1301 (1964).

46. DANISH CRIM. CODE art. 253 ( ), "evident peril to life;" ITALIAN CRIM. CODE art. 593 ( ), "wounded or otherwise in peril;" POLISH CRIM. CODE art. 247; "in a situation directly endangering life"; PORTUGUESE CRIMINAL CODE art. 2368 (1964) applies only when the individual has been "attacked with violence"; RUMANIAN CRIMINAL CODE, art. 489, "in danger of death" (1964); TURKISH CRIMINAL CODE art. 476 (1964). "wounded or otherwise in danger of his life."

47. BELGIAN CRIMINAL CODE art. 422 bis, and art. 422 ter (1960).

48. FRENCH PENAL CODE art. 63 (1959).

49. GERMAN CRIMINAL CODE art. 330 c. (1871).

50. DUTCH PENAL CODE art. 450 (1960).

51. RUSSIAN PENAL CODE § 127 (1960). *See* Note, *The Failure to Rescue: A Comparative Study*, 52 COLUM. L. REV. 631, 637 (1952).

CONCLUSION

It would be naive to assume that merely enacting legislation imposing a positive duty upon physicians to render emergency medical aid would be a panacea to the problems now facing the medical profession. What it would do, however, would be to force the profession to take a step in the direction of a practice of medicine that *always* places human life above economic considerations. Clearly, the physician who refuses to stop to save a life is, in essence, saying that he places a higher value on the economic considerations of the moment than he does on the human life at stake.[52] There are those who would say that this is grossly unfair. They would argue that the physician is placed in an untenable position; for if he stops to render aid, his altruism will most probably yield a malpractice suit, and the specter of the destruction of his professional standing in the community.

First, it is to be remembered that there has never been a reported case of medical malpractice action for care rendered at the scene of an emergency. Second, if the physician is practicing in one of the thirty-seven jurisdictions that have enacted Good Samaritan Statutes he is liable, in most instances, only for gross negligence or bad faith in the rendering of his medical treatment.

But, in all fairness, it must be remembered that it is to the individual physician that we should direct our attention. He cares not for statistics and is interested only in his liability. How can he be sure that a multitude of these actions have not been quietly settled out of court, regardless of their merit, to avoid the ensuing "disgrace" to the defendant-physician? Suppose that he is the first such emergency medical malpractice suit? There the statistics would offer him little comfort.

It would be unconscionable not to give every consideration to a man who has devoted a major portion of his life to the acquisition of a skill that is vitally needed by the society. It is not unreasonable, despite the apparent groundless nature of these fears, to strive to allay them, and attempt to ameliorate the legal position of the altruistic physician.

A rule of law that would incorporate the best of the European statutes and Good Samaritan Statutes, while maintaining the perspective and discretion shown by the panels conducted under New Jersey rule 4:25B[53] would offer the victim of an accident an increased chance for

52. *Supra* note 26; *See generally*, Karcher, *Malpractice Claims Against Doctors: New Jersey's Screening Procedures*, 53 A.B.A.J. 328 (1967).

53. *See* Goldman, *Are Doctors Ignoring the Law*, 4 TRIAL 19 (1966).

survival and the physician all he could reasonably expect to be legally granted. He would be required to act, but would be liable only for a lack of good faith or gross negligence in the rendering of emergency medical treatment and this is, as has already been stated, not the concern of the competent practitioner. Further, the physician would be protected from the attendant notoriety of the malpractice action through a preliminary hearing by a panel of experts that would render an unemotional and educated analysis of the merits of the complaint. After having received a fair and unbiased hearing, if the physician is found to have performed so negligently as to make him legally liable he should be willing to make amends for his error or omission. For the medical profession to ask for anything more is to request, in essence, that this profession be set above the law.

The scientific strides of the medical profession are impressive, but it is evident that they are beginning to overtake the profession's ethical standards. Unless action is soon taken to relieve the socio-economic pressures upon the physician and to adjust this disparity, there can only be a continued increase in malpractice litigation, with an attendant derogation of the physician's position in the community.

EARLE T. HALE