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## Good Samaritan Law: Impact on Physician Rescuers

Vincent C. Thomas

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## GOOD SAMARITAN LAW: IMPACT ON PHYSICIAN RESCUERS

*Vincent C. Thomas\**

I.	INTRODUCTION .....	149
II.	RATIONALE FOR GOOD SAMARITAN LAWS .....	150
	<i>A. Sudden Cardiac Arrest and Need for Immediate Action</i> .....	151
III.	THE PLIGHT OF THE PHYSICIAN RESCUER.....	152
IV.	REVIEW OF CASES.....	155
	<i>A. Location of Emergency—Inside or Outside a Hospital</i> .....	156
	1. Velasquez v. Jiminez .....	156
	2. Hirpa v. IHC Hospitals, Inc. ....	158
	<i>B. No Pre-existing Duty to Provide Care</i> .....	160
	1. Garcia vs. Fraser .....	160
	2. Burciaga v. St. John’s Hospital .....	161
	<i>C. The Need for Emergency</i> .....	162
	1. Bryant v. Bakshandeh.....	163
	<i>D. No Expectation of Remuneration</i> .....	164
	1. Chamley v. Khokha.....	164
	<i>E. Lessons from Case Law</i> .....	166
V.	A UNIVERSAL GOOD SAMARITAN LAW .....	166
VI.	CONCLUSION .....	167

### I. INTRODUCTION

The intent of Good Samaritan legislation is to protect persons who respond to an emergency from civil liability. It helps encourage those who are at the scene of an emergency situation to help those in need of assistance without the fear

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of legal ramifications in the future—thereby removing barriers to immediate emergency care. However, Good Samaritan legislation is fragmented because each state employs different protections for different groups. As a result, barriers to immediate emergency care are still present, depending on the state in which an emergency provider delivers care. This is particularly true on the part of medical professionals as their standard of care is judged above that of the general public, regardless of whether the emergency occurs inside or outside of the hospital setting. The lack of uniformity in state Good Samaritan legislation leads to barriers in the treatment of emergency victims and is in direct contrast to legislative intent and public health initiatives. The rationale for uniform Good Samaritan law will be reviewed as well as the basic components of uniform legislation. Commentary on how the lack of uniformity affects physicians along with descriptions of case law will further illustrate the need for uniformity in Good Samaritan legislation.

## II. RATIONALE FOR GOOD SAMARITAN LAWS

The rationale for Good Samaritan law finds its basis in common law:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if (a) his failure to exercise such care increases the risk of such harm, or (b) the harm is suffered because of the other's reliance upon the undertaking.<sup>1</sup>

According to the California Court of Appeal in *Colby v. Schwartz*:

Thus, at common law, a physician could with legal impunity refuse to aid a stranger in need of immediate medical care. But a physician who stopped and gave aid created a doctor-patient relationship and thereby assumed a duty of reasonable care towards the patient. Further, under the exigent circumstances of this type of medical care, the quality and quantity of a physician's treatment is necessarily reduced. As a result, the chances of medical failure are increased. Thus, notwithstanding a best efforts attempt, a physician who rendered emergency medical care became the natural target of malpractice actions.<sup>2</sup>

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<sup>1</sup> Restatement (Second) of Torts § 323 (1965).

<sup>2</sup> *Colby v. Schwartz*, 78 Cal. App. 3d 885, 890 (1978).

In 1959, California became the first state to adopt a Good Samaritan statute immunizing from tort liability a physician who “in good faith renders emergency care at the scene of an emergency.”<sup>3</sup> As stated in *Velazquez v. Jiminez*:

In sum, Good Samaritan legislation has, at its core, the goal of encouraging the rendering of medical care to those who need it but otherwise might not receive it (ordinarily roadside accident victims), by persons who come upon such victims by chance, without the accoutrements provided in a medical facility, including expertise, assistance, sanitation or equipment.<sup>4</sup>

In *Childs v. Weis*, the court states “[a] physician is under no legal obligation to practice his profession or render services to whomsoever may request them.”<sup>5</sup> For physicians and other healthcare professionals, the engagement as a rescuer with a victim in need may imply the physician-patient relationship. According to a comprehensive review of Good Samaritan laws by law Professor Victoria Sutton, the rendering of emergency services by a rescuer establishes the physician-patient relationship in 48 states.<sup>6</sup> As a result, depending on the protections of the various Good Samaritan state laws, physicians who act may establish a physician-patient relationship and be held to the standard of any reasonably prudent physician. Such lack of uniformity between state laws significantly influences the confidence that a physician has in coming to the aid of an injured person due to fear of civil liability.

#### A. *Sudden Cardiac Arrest and Need for Immediate Action*

Coming to the assistance of those in need is not a foreign concept in emergency and resuscitation medicine. More than 350,000 deaths occur each year as a result of sudden cardiac arrest. Sudden cardiac arrest is estimated to claim one life every two minutes, taking more lives each year than breast cancer, lung cancer, or AIDS.<sup>7</sup> The time to treatment critically influences the chance of survival for a sudden cardiac arrest victim. An estimated 95% of those who experience sudden cardiac arrest die because they do not receive life-saving defibrillation within four

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<sup>3</sup> CAL. BUS. & PROF. CODE § 2395 (Deering 2015) (originally A.B. 2873, CAL. STATS. 1959, ch.1507).

<sup>4</sup> *Velazquez v. Jiminez*, 798 A.2d 51, 57 (N.J. 2002).

<sup>5</sup> *Childs v. Weis*, 440 S.W.2d 104, 107 (Tex. Civ. App. 1969).

<sup>6</sup> Victoria Sutton, *Is There A Doctor (And A Lawyer) In The House? Why Our Good Samaritan Laws Are Doing More Harm Than Good For A National Public Health Strategy: A Fifty-State Survey*, 6 J. HEALTH & BIOMEDICAL L. 261 (2010).

<sup>7</sup> *Sudden Cardiac Arrest Awareness*, HEART RHYTHM SOCIETY, (2013), <http://www.hrsonline.org/News/Sudden-Cardiac-Arrest-SCA-Awareness>.

to six minutes, the time at which brain and permanent death start to occur.<sup>8</sup> Public health interest groups such as the Heart Rhythm Society and American Heart Association encourage all individuals to respond to a potential sudden cardiac arrest emergency by knowing the signs of cardiac arrest, calling emergency services, and providing CPR and treatment with an external defibrillator.<sup>9</sup>

In such emergent and life-threatening scenarios, public policy should encourage citizens to come to the assistance of people in need. If a person's survival is dependent on the actions of others, society should compel us to act in a time of need. To that end, the parable of the Good Samaritan seems appropriate to the needs of our society from a public health perspective.<sup>10</sup>

Good Samaritan laws, depending on their language, may or may not provide the appropriate protections for healthcare providers thrust into emergency situations. Imagine a scenario where a loved one has suffered a cardiac arrest in a public restaurant, a restaurant which just happens to be hosting the annual meeting of emergency physicians. Despite being surrounded by physicians and nurses, your loved one may not receive aid because those physicians and nurses would be hesitant to help out of fear of litigation regardless of whether that fear is irrational. Instead, the survival of your loved one would be dependent upon the actions of lay rescuers who may not know the intricacies of appropriate chest compressions, the ability to secure an airway, or the use of an automated external defibrillator. Additionally, reliance on an emergency response system may result in lack of coordinated medical care for possibly fifteen to twenty minutes, thereby significantly reducing survivability. This hypothetical scenario could have a more rational outcome, but society does not guarantee legal protections for a physician rescuer.

### III. THE PLIGHT OF THE PHYSICIAN RESCUER

Does the physician have a legal duty to be a rescuer in an emergency situation? Surprisingly, the answer is, it depends. Professor Sutton reviewed statutes from each state to determine which states required a physician to provide assistance.<sup>11</sup> In Vermont,

[a] person who knows that another is exposed to grave physical harm shall, to the extent that the same can be rendered without danger or peril to himself or without interference with important

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<sup>8</sup> Mary Larsen, Mickey Eisenberg, Richard Cummins, & Alfred Hallstrom. *Predicting Survival From Out-of-Hospital Cardiac Arrest: A Graphic Mode*, 22 ANNALS EMERGENCY MED. 1652 (1993).

<sup>9</sup> Hands only CPR has been demonstrated to be effective in life-saving procedures.

<sup>10</sup> See Luke 10:25 (New Revised Standard Version Bible: Catholic Edition).

<sup>11</sup> Sutton, *supra* note 6, at 261.

duties owed to others, give reasonable assistance to the exposed person unless that assistance or care is being provided by others.<sup>12</sup>

Any person violating this can be fined up to \$100.00.<sup>13</sup> In Minnesota,

[a] person at the scene of an emergency who knows that another person is exposed to or has suffered grave physical harm shall, to the extent that the person can do so without danger or peril to self or others, give reasonable assistance to the exposed person. Reasonable assistance may include obtaining or attempting to obtain aid from law enforcement or medical personnel. A person who violates this subdivision is guilty of a petty misdemeanor.<sup>14</sup>

New Hampshire states that a person who renders emergency care has the duty to place the injured person under the care of a person who is qualified to care for such person as soon as possible.<sup>15</sup>

Beyond legal concerns, what ethical and moral grounds are there to act in emergency situations? In 2002, during the wake of September 11, 2001, the American Medical Association presented the Declaration of Professional Responsibility: Medicine's Social Contract with Humanity.<sup>16</sup> The preamble states,

[n]ever in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other . . . [a]s physicians, we are bound in our response by a common heritage of caring for the sick and the suffering . . . [h]umanity is our patient.<sup>17</sup>

The declaration goes so far as to commit to “apply our knowledge and skills when needed, *though doing so may put us at risk*.”<sup>18</sup> Given the high ethical standards the medical community holds itself to, how can physicians knowingly deny emergency care based on their fear of litigation? Physicians are trained to help and to respond to those in need. It goes against training to turn the other way.

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<sup>12</sup> VT. STAT ANN. TIT. 12, § 519(c) (2014)

<sup>13</sup> *Id.*

<sup>14</sup> MINN. STAT. § 604A.01(1) (2016).

<sup>15</sup> N.H. REV. STAT. ANN. § 508:12 (2016).

<sup>16</sup> *Declaration of Professional Responsibility*, AMERICAN MEDICAL ASSOCIATION (2014), <https://www.cms.org/uploads/Declaration-of-Professional-Responsibility.pdf>

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* (emphasis added).

Ironically, it is the duty of legal counsel to advise a physician to turn the other way. Legal counsel must advise the physician to avoid any unnecessary litigation and protect themselves from financial and/or career-ending distress regardless of the moral or clinical callings of the physician. To suggest otherwise could be considered legal malpractice. Perhaps counsel, if present, should immediately throw themselves in front of the physician in times of an emergency. The different reactions to emergency situations between the two professional groups are incongruent at best. Yet, their intent is the same—protection of people and society at large.

Societal expectations also play a significant role in a physician's response to an emergency. Although physicians are legally advised to avoid emergency treatment due to concerns of liability, doing so has costs in the court of public opinion. No protections from public scrutiny would be offered if a passenger on an airplane who suffered significant complications due to a medical emergency learned that when the call for a physician was inevitably made, the physician passenger capable of assisting refused to identify herself and sat in her seat working on their laptop. The physician would be perceived as "selfish" or "cowardly" for not acting when called upon. Although legally there is no obligation to treat, there is a strong negative societal perception. Physicians are held to a higher standard due to the training and expertise they possess. When a physician renders emergency care and the outcome is morbidity or mortality, the public perception is that the physician failed to do their job. What people fail to consider is that the setting of an emergency does not often provide the tools a physician needs to effectively practice his or her craft. Emergency situations, by definition, will eventually result in poor outcomes without intervention. The intent of medical intervention is to alter the outcome. However, a poor outcome does not equate to medical or professional failure.

Immunity for physicians under Good Samaritan laws become further complicated for physicians depending on the location of the emergency care rendered. The question of immunity in the hospital setting varies from state to state. In three states, Good Samaritan laws include hospitals as locations in which physicians will not be held liable.<sup>19</sup> However, the language of each statute is varied. In Alaska, immunity is provided to any person who renders emergency care in the confines of a hospital or any other location.<sup>20</sup> In Colorado, immunity is provided to any person or licensed physician rendering emergency medical attention to an individual at a health care institution.<sup>21</sup> In Oklahoma, immunity is provided

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<sup>19</sup> Sutton, *supra* note 6, at 275.

<sup>20</sup> ALASKA STAT. § 09.65.090 (2016); *Id.*

<sup>21</sup> COLO. REV. STAT. § 13-21-108 (2016); Sutton, *supra* note 6, at 275.

to individuals rendering emergency medical care “wherever required.”<sup>22</sup> In other states such as Kentucky and Oregon, Good Samaritan laws specifically state that hospitals are excluded as places of immunity.<sup>23</sup> In California, care rendered in the hospital setting can only be considered immune from civil liability when the state has declared a “medical disaster” and the care occurs in an emergency room.<sup>24</sup>

Interestingly, these statutes do not define hospital. Specifically, is a cardiac arrest within the hospital the same as that occurring on hospital grounds (*i.e.*, parking lot, hospital lobby, waiting room, ambulance bay)? It is common for a hospital emergency response to be called in these areas when individuals seeking medical attention fail to make it to a physician in time for proper assessment and treatment before suffering a cardiac arrest. Resources and access to life-saving equipment is certainly not as readily available in these areas as they are within an emergency room or an inpatient hospital setting. As a result, a physician’s ability to render emergency care is hampered and judging their ability to effectively care for the emergency victim should be evaluated considering these constraints. Some statutes specify areas or locations where physicians are covered by immunity. The intent of Oregon law is to provide immunity for physicians that participate as team physicians or athletic trainers in athletic events.<sup>25</sup> It specifies emergency medical assistance as:

Medical care provided voluntarily in good faith and without expectation of compensation by a physician licensed under ORS chapter 677 . . . and in the persons professional capacity as a provider of health care for an athletic team at a public or private school or college athletic event or as a volunteer provider of health care at other athletic events.<sup>26</sup>

Restrictions placed on location for physicians rendering emergency medical care can lead to hesitation. Emergency medical care is discouraged when physicians hesitate for fear of the legal consequences of helping an injured person. The variations from state to state only make this worse.

#### IV. REVIEW OF CASES

A review of cases will illustrate some of the critical components of Good Samaritan law and its impact on the acts of physicians within various scenarios.

<sup>22</sup> OKLA. STAT. ANN. tit. 76, § 5(a)(1) (West 2016); Sutton, *supra* note 6, at 275.

<sup>23</sup> OR. REV. STAT. § 30.800(1)(a) (2016); KY. REV. STAT. ANN. § 411.148(1) (West 2010); Sutton, *supra* note 6, at 275.

<sup>24</sup> CAL. BUS. & PROF. CODE § 2395 (West 2016); Sutton, *supra* note 6, at 275.

<sup>25</sup> OR. REV. STAT. § 30.800(1)(b) (2016).

<sup>26</sup> *Id.*



A. *Location of Emergency—Inside or Outside a Hospital*

1. *Velasquez v. Jiminez*<sup>27</sup>

In this case, the plaintiffs Charmaine and Jose Velazquez, individually and as representatives of their deceased son, Conor, sued St. Peter's Medical Center and its staff members Teresa Jiminez, MD, Angela C. Ranzini, MD and others for damages resulting from their negligence during Conor's delivery.<sup>28</sup> Before trial, Dr. Jiminez, the Medical Center, and others settled with the plaintiffs but Dr. Ranzini moved for summary judgment under the Good Samaritan Act.<sup>29</sup>

Mrs. Velazquez was a patient at the Medical Center for the purpose of delivering a baby and Dr. Jiminez was her attending physician.<sup>30</sup> Complications occurred during the delivery when the baby became stuck in the birth canal.<sup>31</sup> After delivering the baby's head, Dr. Jiminez was unable to deliver the rest of the baby's body.<sup>32</sup> Dr. Jiminez called for assistance and Dr. Ranzini responded.<sup>33</sup> Importantly to this case, Dr. Ranzini had no prior relationship or connection with Mrs. Velazquez.<sup>34</sup> Dr. Ranzini attempted to complete the delivery vaginally but was unsuccessful.<sup>35</sup> Dr. Ranzini then assisted in preparing Mrs. Velazquez and the baby for an emergency Caesarean section.<sup>36</sup> The baby was born severely brain damaged and spent his life in a dependent state and died of pneumonia before the age of three.<sup>37</sup>

The Supreme Court of New Jersey considered the applicability of the Good Samaritan Act to emergencies involving a patient occurring within a hospital.<sup>38</sup> In its opinion, the court quoted William L. Prosser in section 56 of the *Handbook of the Law of Torts*, summarizing the common law as "[t]he result of all this is that the Good Samaritan who tries to help may find himself mulcted in damages, while the priest and the Levite who pass by on the other side go on their cheerful way rejoicing."<sup>39</sup> The court points out that New Jersey Good Samaritan law does

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<sup>27</sup> *Velasquez v. Jiminez*, 798 A.2d 51 (N.J. 2002).

<sup>28</sup> *Id.* at 54.

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id. passim.*

<sup>39</sup> *Id.* at 56.

not specify emergency care delivered *in a hospital* setting as immune.<sup>40</sup> The court held that Good Samaritan laws did not apply in the setting of a hospital and held in favor of the plaintiffs.<sup>41</sup> The court chose a narrow interpretation of the law stating:

The Appellate Division read the new language as revelatory of a legislative understanding that “the scene of an accident or emergency” is somewhere other than a hospital or treatment facility, which is staffed and equipped to render medical care. . . . More fundamental to us is the notion that if the Legislature had intended to locationally unlimited immunity urged by Dr. Ranzini, it simply could have said so.<sup>42</sup>

Disturbingly, had this case occurred in the State of Nevada, the court would have held in favor of the defendant because Nevada law states, “Any person licensed [to provide medical care], who renders emergency care or assistance, including, without limitation, *emergency obstetrical care or assistance*, in an emergency, gratuitously and in good faith, is not liable for any civil damages as a result of any act or omissions [unless such acts or omissions were grossly negligent].”<sup>43</sup>

Interestingly, the Supreme Court of New Jersey goes on to state:

Dr. Ranzini’s contention that by not extending Good Samaritan immunity to a hospital we will encourage physicians to simply stand by and allow patients to suffer or die is equally unpersuasive. First, we will not impute such conduct to the highly respected medical profession. Moreover, we note that scholars suggest that physicians’ contracts, hospital protocols, ethical rules, regulatory standards and physicians’ personal relationships operate to make that potential extremely unrealistic relative to a hospital patient.<sup>44</sup>

Essentially the court relied heavily on the ethical and moral standards of physicians in the hospital setting to come to the aid of any patient, regardless of their legal duty, but the court’s purposefully narrow interpretation of the law does not provide

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<sup>40</sup> *Id.* at 58. At the time of this ruling, this same view was shared among 29 other states. Of these 29 states, five had enacted specific provisions applicable to emergency obstetrical care including Arizona, Montana, Nevada, North Dakota and Virginia. See ARIZ. REV. STAT. ANN. § 32-1473 (2014); MONT. CODE ANN. § 27-1-734 (2013); NEV. REV. STAT. § 41.505(3) (2014); N.D. CENT. CODE § 32-03.1-02.1 (2013); VA. CODE ANN. § 8.01-225(A)(2) (2014).

<sup>41</sup> *Velazquez*, 798 A.2d at 65.

<sup>42</sup> *Id.* at 62.

<sup>43</sup> NEV. REV. STAT. § 41.505(1) (2016) (emphasis added).

<sup>44</sup> *Velazquez*, 798 A.2d at 64.

immunity.<sup>45</sup> Admittedly, the standards of physicians are high and most if not all will come to the aid of a colleague in need. However, the impact of this ruling may result in a minor amount of hesitancy by a physician in a similar situation.

The court goes on to state that the choice to extend immunity is that of the legislature, and not the court.<sup>46</sup> Also, that simply because a party is sued does not mean that he or she will be liable.<sup>47</sup> With this statement, the court minimizes the financial and mental hardships that a physician faces when encountering litigation. Often it is simply the threat of litigation that contributes to the ordering of unnecessary tests and procedures. Similarly, the threat of litigation, regardless of the outcome, may result in substandard emergency care or at the very least, strained relationships among colleagues in emergency situations.

## 2. Hirpa v. IHC Hospitals, Inc.<sup>48</sup>

In this case, the Supreme Court of Utah held that a physician, with no prior duty to a patient, may fall under the Good Samaritan statute despite the fact that emergency care was provided in a hospital setting.<sup>49</sup> On June 15, 1989, Yeshi Wordoffa was admitted to the hospital in active labor.<sup>50</sup> Shortly after the arrival of her obstetrician, Wordoffa became unresponsive and her hands began to spasm.<sup>51</sup> The baby was delivered using forceps and Wordoffa was then found to have no heartbeat or respiration and a "Code Blue" was called over the hospital intercom.<sup>52</sup> The hospital's medical director, Dr. Merrill Daines, heard and responded to the Code Blue.<sup>53</sup> Dr. Daines was a specialist in internal medicine, cardiology, and emergency medicine.<sup>54</sup> "Upon arriving into the delivery room, Dr. Daines was asked to 'take over' Wordoffa's care, which he did."<sup>55</sup> After seventeen minutes of resuscitative efforts, Wordoffa was declared dead.<sup>56</sup> The surviving spouse, Haile Hirpa, filed suit in the United States District Court for the District of Utah and alleged negligence on the part of several individuals, including Daines.<sup>57</sup>

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<sup>45</sup> *Id.*

<sup>46</sup> *Id.* at 64-5

<sup>47</sup> *Id.* at 65.

<sup>48</sup> *Hirpa v. IHC Hosps.*, 948 P.2d 785 (Utah 1997).

<sup>49</sup> *Id.* at 788.

<sup>50</sup> *Id.* at 787.

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

Early in the case, Daines moved for summary judgment on the ground that he was immune from liability for negligence as he was acting as a volunteer under Utah's Good Samaritan Act.<sup>58</sup> Summary judgment was granted and the plaintiff appealed.<sup>59</sup> The U.S. Court of Appeals for the Tenth Circuit reviewed the issues presented and concluded that the Good Samaritan Act is silent as to whether it applies to emergencies occurring in hospitals and it requested the Utah Supreme Court to interpret the Good Samaritan provision in this scenario, specifically in a hospital setting by a physician.<sup>60</sup>

Utah's Good Samaritan Act, covering licensed medical providers, states, "[n]o person licensed under this chapter . . . who in good faith renders emergency care at the scene of the emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care."<sup>61</sup> The Utah Supreme Court stated that:

Applying the Utah Good Samaritan Act in this case actually furthers the purpose and intent of the legislation . . . Good Samaritan laws responded to the common law rule that made one liable for negligently rendering voluntary emergency assistance by extending immunity from suit, thereby encouraging humanitarian acts by licensed medical providers . . . Applying the Utah Act in a hospital setting furthers this purpose, as the State of Utah argues in this case and as many other courts have determined . . . It does so by encouraging licensed providers, whose training and expertise may be beneficial in preserving human life but who have no duty to aid, to respond to emergencies whenever and wherever they arise. A patient in a hospital may need emergency care from a volunteer provider as much as any other emergency victim. In addition, it seems arbitrary to subject a volunteer provider who responds to an emergency, although not obligated to do so, to liability merely because his volunteer acts occurred in a hospital.<sup>62</sup>

This opinion directly contrasts to that of the Supreme Court of New Jersey in *Velazquez*. Therefore, not only is the location of the emergency important to the physician, but also the legal jurisdiction. In this case, the Supreme Court of Utah

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<sup>58</sup> *Id.*

<sup>59</sup> *Id.* at 787–88.

<sup>60</sup> *Id.* at 788.

<sup>61</sup> UTAH CODE ANN. § 58-13-2(1) (LexisNexis 2016) (listed as § 58-12-23 at the time the case was decided).

<sup>62</sup> *Hirpa*, 948 P.2d at 789–90.

held that the site of an emergency, whether a hospital or elsewhere, has no bearing on the application of Good Samaritan law.<sup>63</sup> What is pertinent is the licensed professional's duty to treat.<sup>64</sup> Stated differently, an established doctor-patient relationship and subsequent duty to treat will always hold precedence over the application of Good Samaritan law.<sup>65</sup>

### *B. No Pre-existing Duty to Provide Care*

The duty to provide care is rooted in the establishment of a physician-patient relationship. Without a prior relationship with a patient or facility, a physician has no duty to provide care regardless of the circumstances. In the following cases, the application of Good Samaritan law relies on the premise that the physician had no pre-existing duty to provide care.

#### *1. Garcia vs. Fraser*<sup>66</sup>

In this case, the California Court of Appeal made it clear that a distinction must be made between a physician's duty and responsibility to provide emergency medical care and a physician volunteering to provide that care.<sup>67</sup> In this case, the plaintiff was Andres Garcia, a ten year old boy who suffered an injury to his arm during delivery.<sup>68</sup> His mother, Maria Gonzalez, was brought to the hospital on November 19, 2003 with labor contractions but the staff was unable to contact her regular obstetrician.<sup>69</sup> Dr. Fraser was the on-call obstetrician for the emergency department at the hospital; however he was not specifically on call for Gonzalez's original obstetrician.<sup>70</sup> During the delivery, it was noted that the infant had a heart rate deceleration and Dr. Fraser noted a shoulder dystocia where the shoulder becomes lodged under the pelvis of the mother, thereby impeding delivery.<sup>71</sup> Dr. Fraser used a "corkscrew maneuver" to remove the baby.<sup>72</sup> The baby was ten pounds, ten ounces at birth, and noted to have Erb's palsy causing decreased movement in the left upper shoulder area.<sup>73</sup> A suit was filed alleging that Dr.

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<sup>63</sup> *Id.* at 790.

<sup>64</sup> *Id.*

<sup>65</sup> *See id.*

<sup>66</sup> *Garcia v. Fraser*, No. 246267, 2013 WL 6620852 (Cal. Ct. App. Dec. 16, 2013). Under Cal. Rules of Court, Rules 8.1105, 8.1110, and 8.1115 this opinion is not officially published and subject to citation restrictions. However, it is still useful for the purposes of this article.

<sup>67</sup> *Id.* at \*4-\*5.

<sup>68</sup> *Id.* at \*1.

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

Fraser negligently delivered Andres vaginally rather than by cesarean section.<sup>74</sup> Dr. Fraser asserted several defenses, including the Good Samaritan defense.<sup>75</sup>

The Court of Appeal struck down the Good Samaritan defense in this case stating, “When a physician renders emergency care *as part of his duties and responsibilities in the medical facility*, courts have not allowed the physician to claim the protection of the Good Samaritan statutes.”<sup>76</sup> Dr. Fraser had testified that he was on call to provide medical services to patients in labor as the on-call OB/GYN for the emergency department.<sup>77</sup> Subsequently, Dr. Fraser’s Good Samaritan defense could not be affirmed.<sup>78</sup>

## 2. Burciaga v. St. John’s Hospital<sup>79</sup>

In this case, the California Court of Appeal held that a pediatrician who rendered emergency care owed no duty to an infant even though he was a hospital staff physician.<sup>80</sup> The plaintiff, William Burciaga, (W.B.) was born at St. John’s Hospital on September 12, 1980 at 9:30 a.m.<sup>81</sup> During his birth, the obstetrician noted that the umbilical cord was entangled about W.B.’s neck and feet and he suffered from severe anoxia.<sup>82</sup> A pediatrician was requested to the delivery room “stat.”<sup>83</sup> Dr. Gibson, a pediatrician who was visiting his own hospital patients, responded to the call within a minute.<sup>84</sup> He discovered that the infant was cyanotic and having respiratory distress.<sup>85</sup> Gibson applied suction and administered oxygen.<sup>86</sup> Dr. Gibson decided that W.B. required neonatal intensive care and because St. John’s hospital did not provide the service, he contacted Ventura County General neonatal unit for transfer.<sup>87</sup> The unit was full and thus Gibson sought other placement.<sup>88</sup> Children’s Hospital in Los Angeles accepted W.B. at about 5:00 p.m. that day.<sup>89</sup> In the interim, Gibson cancelled

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<sup>74</sup> *Id.* at \*2.

<sup>75</sup> *Id.*

<sup>76</sup> *Id.* at \*4. (emphasis added).

<sup>77</sup> *Id.* at \*20.

<sup>78</sup> *Id.* at \*21.

<sup>79</sup> *Burciaga v. St. John’s Hosp.*, 187 Cal. App. 3d 710 (Cal. Ct. App. 1986).

<sup>80</sup> *Id.* at 713.

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> *Id.*

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

his office appointments and treated W.B.<sup>90</sup> W.B. suffered from cerebral palsy and permanent neurological damage and brought malpractice action against the obstetrician, St. John's Hospital, and Dr. Gibson.<sup>91</sup> He contended that Gibson did not commence treatment promptly and that he delayed in transferring him to a neonatal unit.<sup>92</sup> Gibson sought immunity under Good Samaritan law stating that he did not have a pre-existing duty to act.<sup>93</sup>

The court ruled:

Gibson's declaration provides a reasonable inference that he did not have an existing duty to treat William and that he acted as a volunteer. William was not Gibson's patient and [the obstetrician] did not customarily refer patients to him. Gibson was present in the hospital only because he was treating his own hospitalized patients. He cancelled his office appointments for the day in order to treat William. That a medical emergency fortuitously occurred while he was in the hospital creates no duty to plaintiff. There was no evidence that Gibson was employed by the hospital, and it is not a reasonable inference that because he was an active staff member, the hospital had designated him to treat newborns in the event of an emergency.<sup>94</sup>

In this case, the court recognized that the physician had no pre-existing duty to provide care for the newborn as he was not his patient.<sup>95</sup> Interestingly, the court specifically stated that while the physician was an active staff member, it is not reasonable to infer the hospital designated him to treat newborns in the event of an emergency.<sup>96</sup> Without an established physician-patient relationship and no duty to provide emergency care as an employee of the hospital, immunity under Good Samaritan law was upheld.<sup>97</sup>

### C. *The Need for Emergency*

Good Samaritan law should apply to emergency situations where the care delivered must be performed in a timely fashion, during unforeseen and irreversible circumstances, where the delivery of said care would be considered

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<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

<sup>93</sup> *Id.*

<sup>94</sup> *Id.* at 716.

<sup>95</sup> *Id.*

<sup>96</sup> *Id.*

<sup>97</sup> *Id.* at 716-17.

life-saving or life-preserving. The following case describes a situation where the defendant invokes Good Samaritan law as protection from liability. However, the court recognized the situation and the defendant's actions as not constituting an emergency.

### 1. Bryant v. Bakshandeh<sup>98</sup>

In this case, an infant by the name of Shaun Bryant was to undergo a corrective surgery for a condition of imperforate anus.<sup>99</sup> Prior to the operation and after the baby was anesthetized, a catheter was required to be inserted into the urethra of the patient.<sup>100</sup> After several failed attempts, Dr. Bakshandeh, a urologist, answered a "stat" call for assistance.<sup>101</sup> Dr. Bakshandeh attempted to insert the catheter into the urethra but was unable to do so and recommended that a cystoscopy be performed to insert the catheter.<sup>102</sup> Bakshandeh left the room for about eight or ten minutes and returned for the cystoscopy.<sup>103</sup> He performed the cystoscopy, made several attempts to insert the catheter but was not successful.<sup>104</sup> In his medical reports, Baskhandeh stated that he performed the procedures on an emergency basis.<sup>105</sup> Shaun died three days later from an infection resulting from perforation of his rectal pouch during the pre-operative procedures.<sup>106</sup>

The Bryants sued for wrongful death, negligence, and failure to adequately inform of possible complications associated with surgery.<sup>107</sup> Dr. Baskshandeh moved for summary judgment based on the Good Samaritan laws.<sup>108</sup> According to California law:

No licensee, who in good faith upon the request of another person so licensed, renders emergency medical care to a person for medical complication arising from prior care by another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by such licensed person in rendering such emergency medical care.<sup>109</sup>

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<sup>98</sup> Bryant v. Bakshandeh, 226 Cal. App. 3d 1241 (Cal. Ct. App. 1991).

<sup>99</sup> *Id.* at 1243.

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> *Id.* at 1244

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> *Id.*

<sup>108</sup> *Id.*

<sup>109</sup> CAL. BUS. & PROF. CODE § 2396 (Deering 2016).



In its decision, the court specifically stated that the plaintiffs did not present evidence that the defendant had a pre-existing duty to render professional care.<sup>110</sup> However, the court did state that whether the event constituted an emergency or required immediate action remained in question.<sup>111</sup> “Here, although Shaun was anesthetized, the contemplated surgical procedure had not begun and, in fact, could not begin until Bakshandeh inserted the catheter. Moreover, Bakshandeh was informed the surgery was elective.”<sup>112</sup> As such, the court held that Bakshandeh was not entitled to immunity under the Good Samaritan statute, on summary judgment, due to the question of the presence of an emergency.<sup>113</sup>

The situation was not an emergency given that the patient was undergoing an elective procedure, that the surgical procedure had not started, and that the procedure could not start until the catheter was inserted.<sup>114</sup> These facts provided time for the acting physician to assess the situation and potentially cancel the procedure. The situation was not an emergency because the lack of intervention would not result in a poor outcome.

#### *D. No Expectation of Remuneration*

The expectation of remuneration for services provided establishes that a physician provided services in the setting where the physician is establishing a relationship with a patient. In the following case, a physician responds to an emergency situation but expects payment for services rendered. As such, the Good Samaritan defense was not upheld.

##### *1. Chamley v. Khokha*<sup>115</sup>

In this case, the North Dakota Supreme Court held that a general surgeon, as a salaried hospital employee who received remuneration for assisting in surgery, had an expectation of remuneration, and thus, was precluded from claiming immunity under the Good Samaritan Act.<sup>116</sup> “On February 2, 2004, Rosie Chamley was admitted to Mercy Medical Center to undergo a surgical procedure to remove kidney stones.”<sup>117</sup> The surgery was performed by her urologist, Dr. Shahin.<sup>118</sup> Dr. Shahin was not an employee of Mercy Medical Center but had

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<sup>110</sup> *Bryant*, 226 Cal. App. 3d at 1246.

<sup>111</sup> *Id.* at 1247.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> *Chamley v. Khokha*, 730 N.W.2d 864 (N.D. 2007).

<sup>116</sup> *Id.* at 868.

<sup>117</sup> *Id.* at 865.

<sup>118</sup> *Id.*

privileges to perform surgery.<sup>119</sup> Following the surgery, Chamley experienced excessive bleeding and her condition became life-threatening.<sup>120</sup> Dr. Shahin returned to the operating room and found that the kidney was the source of bleeding and would have to be removed but had difficulty in identifying the appropriate blood vessels.<sup>121</sup> Dr. Shahin requested that Dr. Khokha assist with the kidney removal.<sup>122</sup> “Dr. Khokha, a Mercy Medical Center general surgeon with vascular credentials, was in the doctors’ lounge waiting for surgical personnel so he could perform a scheduled surgery on his own patient.”<sup>123</sup> “At the time, Dr. Khokha was a salaried hospital employee and staff physician at the hospital.”<sup>124</sup> When asked to help, Dr. Khokha immediately went into the operating room to assist.<sup>125</sup> During the removal, the vena cava or main blood vessel draining blood to the heart, was damaged and had to be repaired by Dr. Khokha.<sup>126</sup> The repair stopped the internal bleeding. Chamley was transferred the following day to a Bismarck hospital where she later died.<sup>127</sup> Dr. Khokha billed for his services.<sup>128</sup>

William Chamley, Rosie’s son, filed suit alleging Dr. Khokha and Mercy Medical Center were responsible for Rosie Chamley’s wrongful death.<sup>129</sup> The district court granted summary judgment concluding that Dr. Khokha was a Good Samaritan and therefore immune from suit.<sup>130</sup> On appeal, William Chamley argued that the district court erred in granting summary judgment under the Good Samaritan statutes because Dr. Khokha was employed to provide hospital patients with vascular surgical skills.<sup>131</sup> The court stated:

Here, William Chamley argues Dr. Khokha must have expected remuneration when he entered the operating room because . . . Dr. Khokha is a hospital employee who expects to be paid for medical services rendered in the hospital . . . . The contract prohibited Dr. Khokha from having any other employment in the medical field. . . . Dr. Khokha was required

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<sup>119</sup> *Id.*

<sup>120</sup> *Id.*

<sup>121</sup> *Id.*

<sup>122</sup> *Id.* at 865–66.

<sup>123</sup> *Id.* at 866.

<sup>124</sup> *Id.*

<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> *Id.* at 867.

<sup>129</sup> *Id.* at 866.

<sup>130</sup> *Id.*

<sup>131</sup> *Id.*

to provide surgical services to hospital patients. . . . He was compensated by the hospital, on both a salary and an incentive basis. . . . On the basis of these facts and others in the record, we believe as a matter of law that Dr. Khokha had an *expectation of remuneration and that he is not immune from liability* under the Act.<sup>132</sup>

### *E. Lessons from Case Law*

Review of the previous cases demonstrates some universally accepted criteria for the immunity provided by Good Samaritan laws in the states. The first is that the situation in which care is rendered must be considered an emergency.<sup>133</sup> The emergency standard is a general one and not just met by the physician declaring an emergency.<sup>134</sup> Second, the physician must provide the care without any remuneration.<sup>135</sup> It is difficult to demonstrate that services were provided in good faith when the physician bills the patient for emergency services and expects payment.<sup>136</sup> Third, the care provided must not be grossly negligent.<sup>137</sup> How this is interpreted varies from state to state with many states requiring care that is not willfully or wantonly reckless.<sup>138</sup> Lastly, but likely most importantly, there must be no pre-existing duty to provide care to the victim of the emergency.<sup>139</sup> If a doctor-patient relationship has been established, emergency care must be provided and Good Samaritan laws do not apply.<sup>140</sup>

Case law is less clear in regards to the location of emergency.<sup>141</sup> Certain states provide immunity to healthcare providers in hospital settings whereas others explicitly exclude hospitals.<sup>142</sup> Due to the variations in individual state laws, cases could have different outcomes based on the jurisdictions in which the care is given.

## V. A UNIVERSAL GOOD SAMARITAN LAW

Conceptually, the goal of a universal Good Samaritan law should allow for: uninhibited rendering of emergency care to those in need without fear of

<sup>132</sup> *Id.* at 867–68 (emphasis added).

<sup>133</sup> *See supra* notes 98–114 and accompanying text.

<sup>134</sup> *Id.*

<sup>135</sup> *See supra* notes 115–32 and accompanying text.

<sup>136</sup> *Id.*

<sup>137</sup> *See supra* note 43 and accompanying text.

<sup>138</sup> *Id.*

<sup>139</sup> *See supra* notes 66–97 and accompanying text.

<sup>140</sup> *Id.*

<sup>141</sup> *See supra* notes 27–65 and accompanying text.

<sup>142</sup> *Id.*

litigation; universal applicability in emergency situations regardless of the medical background of the rescuer; and promotion of public health and human life.

Components of a universal Good Samaritan law would start with definitions of emergency care and emergency situation. Emergency care may be defined as services rendered to a patient that, if withheld, would result in death or substantial bodily harm. Emergency care can be delivered in both in-hospital and out-of-hospital settings and by medical and non-medical personnel. An emergency situation may be defined as an event where emergency care is needed to prevent death or serious bodily injury but is not immediately available when the emergency situation arises. In order for Good Samaritan laws to then apply, emergency care must be rendered in an emergency situation.

The lack of a doctor-patient relationship at the time emergency care is rendered is critical to Good Samaritan law. Any physician that has a previously established relationship with a patient during the time emergency care is rendered would not be considered immune under Good Samaritan law. Additionally, physicians must be held to an appropriate standard and Good Samaritan law cannot and should not obviate this standard, including an emergency situation where an established doctor-patient relationship exists. An emergency room physician who is contracted to work in a hospital's emergency room, and thus establishes a doctor-patient relationship with any patient entering said emergency room would not be considered immune under Good Samaritan law. However, an emergency room physician who renders emergency care outside of their typical work place, constituting an emergency situation should be immune under Good Samaritan law. Finally, equipment and services are drastically different outside of an emergency room setting. Therefore, physicians and other medical professionals cannot be held to the same standard of care outside of an emergency room as they are inside. But even in this situation however, emergency care must never be grossly negligent.

Remuneration for services rendered should not be given or expected in an emergency situation where a doctor-patient relationship does not exist. Any remuneration given or expected should preclude immunity from Good Samaritan law. Finally, Good Samaritan law protections should encompass all individual rescuers, *regardless of medical background*. Therefore, any exceptions for physicians, nurses, or other healthcare providers must be omitted from any universal law. To add such verbiage would hinder the Good Samaritan law's universal applicability in emergency situations.

## VI. CONCLUSION

Good Samaritan law is so varied from state to state that it results in confusion as to when immunity is afforded to a treating physician. This confusion may lead to hesitancy in emergency situations, which an injured person can ill-afford. As

suggested by Professor Sutton, "Good Samaritan laws in the United States vary in such significant ways that even the most strident of the would-be rescuers is likely to pause before undertaking a rescue of anyone in need."<sup>143</sup> Professor Sutton goes on to suggest that the application of a federal statute or a model Good Samaritan Act by the Governor's Association may help address the discrepancies between states and allow the physician rescuer to respond to emergency situations without hesitancy.<sup>144</sup>

Another potential solution is for the National Conference of Commissioners on Uniform State Laws (NCCUSL) to help draft and establish a uniform Good Samaritan Act that could be adopted by all states, resulting in the repeal of the current patchwork of state law. Such a law could result in a clear understanding of the role of a physician in any emergency, in any setting and at any time. A uniform law would encourage physicians to come to the immediate assistance of those in need without hesitation. It would also encourage attorneys to more confidently advise their physician clients regarding their legal duties and immunities.

Health emergencies are immune to sex, race, creed, etc. They are also immune to location and medical background. Public policy should afford this same immunity to physician rescuers to allow them to act first and concern themselves with liability later. Providing physicians with an opportunity to exercise their skills should be in the interest of the state, just as promoting human life. Good Samaritan law should help protect the community as a matter of public health.

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<sup>143</sup> Sutton, *supra* note 6, at 299.

<sup>144</sup> *Id.*