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Using Good Samaritan Acts to Provide Access to Health Care for the Poor: A Modest Proposal

*Bridget A. Burke**

I. INTRODUCTION

The Proposal

It is not news that the United States' health care system, or the lack of one, is extremely costly, inefficient, and fails to meet the needs of many citizens. What is news, however, is the way in which some states are attempting to deal with access, cost, and liability problems related to health care delivery for the poor.¹ This issue is of increasing importance because the high costs of health care have made the problem of access more acute than ever before. This fact is complicated by the efforts of all health care payors, in particular the government, to control costs. While cost containment efforts are underway to reduce or control government spending on health care, health care needs are not similarly decreasing. These expenses must, however, be borne by someone, and as a result the entire population is affected by the costs associated with meeting the health care needs of the poor or the ultimate costs associated with neglecting these needs.

This article will examine one proposal to address the access, cost, and liability problems related to providing health care to the poor. This proposal would amend traditional Good Samaritan statutes by granting immunity to physicians who provide services to those without access to care. Analysis of this proposal will include a review of one law in particular, its supporters and oppo-

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1. The use of the words poor and indigent in this article refers to people who are employed in low-paying jobs but have no health insurance, people who are underinsured, and people who are homeless. Some commentators describe this category of people as the medically indigent. Many of these people exist in a health care coverage limbo because they make too little money to afford health care, yet too much to or for other reasons do not qualify for the government sponsored health care program, Medicaid.

nents, and their observations concerning the public policy ramifications of its implementation. Prior to analyzing the expansion of traditional notions of the Good Samaritan doctrine, it is necessary to understand the basis for these laws.

II. GOOD SAMARITAN ACTS

History

Good Samaritan statutes have been a part of the legislative landscape since the late 1950's.² These statutes were a result of legislators' perceptions that highway accident victims would be ignored by potential rescuers because of the rescuers' concerns about liability. The simple answer to this problem seemed to be the enactment of statutes creating immunity from civil liability for those who volunteered in medical emergencies. Also, today's comprehensive emergency medical systems were not in existence during the 1950's and 1960's, when most of these laws were passed. Prior to the development of emergency medical services, society depended upon individuals to a greater extent to provide whatever care they were capable of providing in the event that they came upon an accident.³

Today, each state and the District of Columbia has some form of Good Samaritan law. The majority of jurisdictions provide immunity for Good Samaritans rendering aid regardless of medical training, while some jurisdictions grant immunity only to those with medical training. Although each state has this type of law in place, no two statutes are alike. The variations include differences regarding the class of persons protected by the law, the extent of the protection, and the circumstances required for immunity to attach. Despite their differences, these acts have traditionally included many, if not all, of the following characteristics. First, as the Good Samaritan doctrine originated from concerns about roadside accident victims, these laws typically required that an emergency existed at the situs of care. Second, the volunteer could not have had an independent existing duty to treat the individual. Third, the care was given without an expectation of reimbursement. Finally, most laws included a requirement that the care be provided in good faith and that immunity be available only for neg-

2. Under common law principles of tort, there is no duty to protect another from harm. California enacted the first Good Samaritan act in 1959.

3. John A. Norris, *Current Status and Utility of Emergency Medical Care Liability Law*, 15 FORUM 377, 394 (1980).

ligent acts. Therefore, no immunity existed for gross negligence or intentional, willful, or wanton misconduct.

Effectiveness

The twin purposes underlying Good Samaritan legislation, encouraging emergency volunteerism and providing immunity for such action, are laudable, but of questionable relation to actual physician conduct. In fact, there is much debate as to whether the statutes that flow from these purposes are responsible for encouraging physician assistance.⁴ No causal connection has ever been established between the existence of Good Samaritan statutes and increased medical volunteerism. On the contrary, studies attempting to gauge the influence of these statutes on physician behavior have shown that physician volunteerism is unaffected by these laws.⁵ Apparently, the presence of Good Samaritan laws has made little impact on physicians' willingness to aid the injured as Good Samaritans.⁶

Consequently, Good Samaritan laws have been consistently criticized over the years for being nothing more than legislative placebos.⁷ These laws have remained on the books not due to demonstrated effectiveness, but because they promote favorable societal policies. Since these laws served to assuage physicians' fears of liability, and because they seemed to encourage positive behavior, they were not objectionable.

Expansion of the Doctrine

Despite the lack of data suggesting the effectiveness of Good Samaritan acts, some states are amending these statutes to create immunity for physicians who provide care to the indigent.⁸ The

4. Robert A. Mason, *Good Samaritan Laws-Legal Disarray: An Update*, 38 MERCER L. REV. 1439 (1987); Eric A. Brandt, *Good Samaritan Laws-The Legal Placebo: A Current Analysis*, 17 AKRON L. REV. 303 (Fall 1983); Frank J. Helminski, *Good Samaritan Statutes: Time for Uniformity*, 27 WAYNE L. REV. 217, 232 (1980).

5. In a study conducted by the American Medical Association in 1963, the results disclosed that the existence of Good Samaritan laws made no difference in the willingness of physicians to stop and assist those requiring aid. In fact, 51.5% of the respondents said they would stop to furnish emergency aid if the statutes were in effect, and 48.8% if no statutes were in effect. Law Department of the American Medical Association, *Professional Liability Survey*, 189 JAMA 859 (1964).

6. Helminski, *supra* note 4.

7. Brandt, *supra* note 4.

8. See D.C. CODE ANN. § 2-1345 (Supp. 1992); FLA. STAT. ANN. § 768.13(4)(3) (West Supp. 1992); GA. CODE ANN. § 51-1-29.1 (Supp. 1991); HAW. REV. STAT. § 663-1.5(c) (1988).

announced objective of these laws is to increase access by encouraging providers to volunteer,⁹ or in some cases receive remuneration,¹⁰ to render medical services to those who otherwise might not receive care in exchange for the guarantee that the provider will not be held liable for negligent care. Most of these laws apply to care provided in nonprofit or government-sponsored clinics for the poor, and some of them are specifically targeted to increase access to medical care for poor pregnant women.

Arguably, the access problem has become so grave that any attempt to broaden access to those without health care should be welcomed. After all, in the absence of these amended statutes, many of these people would be left with no care. Under these circumstances, relinquishing their right to sue for negligent care in exchange for access to care may be a necessary compromise. If the status quo is maintained, and Good Samaritan laws are not expanded, there may simply be no place for these people to obtain care.

Without a doubt, the end hoped to be achieved through this policy is praiseworthy, but the means may be flawed because Good Samaritan acts have never been shown to be necessary or useful statutes. Therefore, the issue is whether it is appropriate for policymakers to develop health care policy for the poor upon well-intentioned, but ineffective, existing Good Samaritan laws.

III. CURRENT TREND

Access

The movement to expand Good Samaritan acts is driven by calls for increased access to health care. By turning to their Good Samaritan acts to expand access, states are seeking to limit, or foreclose, a poor patient's ability to sue for negligent care provided by volunteer or state-employed physicians. In essence, this policy requires poor people to forsake their ability to sue in exchange for access to health care. This public policy is predicated on the assumption that liability considerations are directly responsible for limiting access. However, if limited access is the result of other, or multiple, factors, the rationale for this policy is diminished. Therefore, it is necessary to examine the causes of wide spread reduced access to health care.

To begin, there is no denying that the costs associated with lia-

9. See D.C. CODE ANN. § 2-1345 (Supp. 1992).

10. See MO. ANN. STAT. § 105.711 (Vernon Supp. 1992).

bility insurance have dramatically impacted the cost of health care delivery and access.¹¹ The 1970's and 1980's crises in availability and affordability of medical malpractice insurance affected all physicians and their practices. The most extraordinary increases in the cost of malpractice premiums occurred in the specialty of obstetrics.¹² These costs contributed to the reduction in the number of physicians providing obstetrical services. Not surprisingly, there are ongoing shortages in obstetrical care across the country.¹³

Although the liability crisis certainly exacerbated access problems, it is not clear that the liability crisis is singularly responsible for the crisis in access. It is more accurate to view access problems as resulting from a number of contributing factors. For instance, low reimbursement rates have also contributed to reduced numbers of physicians willing to serve government subsidized patients.¹⁴ Again, this situation is particularly acute in obstetrics where the allocated cost of insurance exceeds Medicaid's reimbursement rate in many cases.¹⁵

Another factor contributing to access problems is simply the skyrocketing costs associated with health care. As a result of these costs, millions of Americans cannot afford insurance coverage or have inadequate coverage.¹⁶ While some people in this situation will forego health care, others will seek care without paying for it, and still others will depend upon the government for assistance.

11. One of the fastest growing components of physician practice costs has been professional liability insurance. Average premiums for self-employed physicians have increased at an average annual rate of 21.9%, rising from \$5,800 in 1982 to \$12,800 in 1986. During this period, average liability insurance premiums in internal medicine increased from \$3,700 to \$7,100. In obstetrics and gynecology, premiums increased from \$10,800 to \$29,300. The high premiums are attributable to increased incidence of malpractice claims and rising levels of jury awards.

American College of Physicians, *Access to Health Care*, 112 ANNALS INTERNAL MED. 641, 648 (1990) (footnote omitted) (Center for Health Policy Research, American Medical Association, *Socioeconomic Characteristics of Medical Practice* (1987)). See also Victoria P. Rostow, et al., *Medical Professional Liability and the Delivery of Obstetrical Care*, 321 NEW ENG. J. MED. 1057 (1989).

12. Ruth Gastel, *Medical Malpractice*, INS. INFO. REP. (Insurance Information Institute) June 1992, at 1.

13. Sara Rosenbaum & Dana Hughes, *The Medical Malpractice Crisis and Poor Women*, in PRENATAL CARE, REACHING MOTHERS, REACHING INFANTS 233, 233-234 (Institute of Medicine, National Academy Press, Wash. D.C., 1988).

14. Laurie Garret, *Care Bows to Costs: Insurance Rates are Driving Obstetricians from the Delivery Room in Record Numbers*, NEWSDAY, July 12, 1988, at Discovery Section, at 1.

15. Rostow, *supra* note 11, at 1058.

16. Some studies estimate that 37 million Americans are without any form of health insurance, and another 50 million are underinsured. American College of Physicians, *supra* note 11, at 646.

The increased incidence of defensive medicine is also adding to higher overall health care costs. Costs are increased by physicians ordering unnecessary tests and procedures in an effort to protect themselves from the possibility of a patient later claiming the physician failed to act appropriately.¹⁷

An additional factor creating access difficulties stems from cost containment measures. For instance, government cutbacks and inadequate reimbursement in the specialty of obstetrics have resulted in the unavailability of prenatal care to many poor women. Inadequate prenatal care increases the likelihood of bad birth outcomes and higher costs.¹⁸ The prospect of bad outcomes brings the access dilemma full circle; physicians become reluctant to deliver the babies of these patients who have had little or no health care services during their pregnancies and whose medical histories are unknown.¹⁹

These circumstances demonstrate that the issue of access is multidimensional, and that there are a number of causes for the crisis in access. Using Good Samaritan acts as a means of reducing the access problem assumes that the underlying cause stems simply from liability concerns. Such a solution might be satisfactory if this were a less complex problem; however, it is complicated, and meaningful policy to address it requires careful consideration of all the issues that affect the availability of health care. Despite the foregoing, some jurisdictions are attempting to address the access issue by amending existing Good Samaritan legislation to immunize the conduct of certain physicians providing health care generally to the indigent, while others are limiting the expansion of the doctrine to the provision of care for more specific populations. One jurisdiction that concluded that liability concerns constitute the root cause of health care access problems is the District of Columbia.

The Example of the District of Columbia

Effective August 17, 1991, the District of Columbia amended its Good Samaritan Act to provide immunity for volunteer physicians, nurse-midwives, and nurses providing obstetrical care.²⁰

17. The American Medical Association estimates that defensive medicine added \$11.7 billion to the cost of physician's services in 1985. Martin Hatlie, *Professional Liability: The Case for Federal Reform*, 263 JAMA 584 (1990).

18. Thomas S. Nesbitt, et al., *Access to Obstetric Care in Rural Areas: Effect on Birth Outcomes*, 80 AM. J. PUB. HEALTH 814 (1990).

19. Garret, *supra* note 14.

20. See D.C. CODE ANN. § 2-1345 (Supp. 1992).

Previously, the Act indemnified qualified free clinics, but exempted high risk specialties like obstetrics from the coverage of the Act. The new law grants immunity to physicians, nurses, and nurse-midwives who voluntarily provide obstetric and gynecologic services in free clinics. In addition, it creates immunity for District of Columbia public health clinics and the District as indemnifier of qualified free clinics as to claims arising from obstetric or gynecologic care rendered. The immunity granted by the amendment does not extend to intentional wrongs or to conduct in willful or wanton disregard for the health or safety of patients.

This action illustrates an attempt to confront lack of access to care by limiting exposure to liability. Proponents of the amendment, including the Medical Society of the District of Columbia, the Coalition Against Lawsuit Abuse, and the American Tort Reform Association, hailed the amendment as promoting volunteerism and creating access for those most in need. The District of Columbia Trial Lawyers Association, however, argued that the right of a person to sue is an inalienable right and should not cease to exist simply because the person is poor.²¹

Prior to the amendment of the Act, the Medical Society maintained that scores of qualified physicians would like to volunteer at clinics but were unable to do so because their own malpractice insurance would not cover such services.²² According to the Medical Society, prior to the amendment there were only three obstetricians volunteering in free clinics; since passage of the amendment, 14 obstetricians have become volunteers in free clinics as a result of the amended legislation. This number constitutes 15% of the Medical Society's obstetrician section. In addition, due to the increased number of volunteer obstetricians, one free clinic that previously did not provide obstetrical care now provides such services. The Medical Society has urged the City Council to extend the immunity provision to all health care professionals, not just obstetricians and gynecologists.²³ Beyond the encouraging numbers of physician volunteers, there is no data to date concerning the efficacy of this piece of legislation.²⁴ Furthermore, at this time advocates of the poor are wrestling with the merits of this proposition.

21. Sandy Rovner & Scott Streitfeld, *Insuring Good Health*, WASH. POST, June 3, 1991, at C5.

22. *Doctors for the Homeless*, WASH. POST, June 11, 1990, at A14.

23. *Council Committee Approves Immunity for MD Volunteers*, PHYSICIAN, May 1991, at 5; Rovner, *supra* note 21.

24. Telephone Interview with Thomas L. Johnson, Director of Legislative Affairs and Public Health, Medical Society of the District of Columbia (Mar. 3, 1992).

Advocates' Concerns

The District of Columbia legislation has been met with cautious optimism by most advocacy groups for the homeless and indigent. Most of these groups have not articulated a position on the issue of the expansion of Good Samaritan acts to cover the health care needs of the poor. However, several representatives of these groups have voiced concerns about the poor trading their right to sue in exchange for health care.²⁵ Although these groups are in favor of any measure to increase access to health care, they all expressed reservations about a system of health care delivery largely dependent upon volunteers. These concerns are echoed in a 1990 American College of Physicians' position paper regarding access, which appeared in the *Annals of Internal Medicine*. On the issue of expanding charity care to overcome access barriers the authors conclude:

[T]here are inherent risks to patients and society in a system that relies solely on benevolence for the provision of health care services. History has shown that under such a system, health care services are not equally available to all, and poor persons typically either do not receive needed care or receive services of lesser quality. Therefore, expansion of charity care does not constitute an appropriate response to the access problem.²⁶

There appears to be a difference in opinion among these groups regarding short term and long term advocacy goals. To some advocates the amendment of existing Good Samaritan acts to provide access to the indigent is viewed as a step forward in addressing the health needs of the poor. These advocates feel very strongly that the immediate provision of direct health care services is their overriding concern.²⁷ Those ascribing to this viewpoint see the forfeiture of a poor person's ability to sue in exchange for health care as an unfortunate, but acceptable, trade-off. Among these advocates, there is a sense that an indigent person's right to sue is an illusory right, or at least one so rarely exercised as to be meaningless, whereas his or her need to receive health care services is very real.

On the other hand, there are advocates who fear that the consequence of trading away an ability to sue for negligent care in exchange for access to services may have a detrimental impact on the

25. Telephone Interview with Freda Mitchem, National Association of Community Health Centers, Washington D.C. (Apr. 17, 1992); Telephone Interview with Lydia Williams, National Coalition for the Homeless, Washington D.C. (Apr. 21, 1992).

26. American College of Physicians, *supra* note 11, at 643.

27. Telephone Interview with Renee Wallis, Executive Director, Zacchaeus Clinic, Washington, D.C. (Apr. 17, 1992).

rights of the poor and disenfranchised in the long run. Their concern is that this policy will only further alienate and stratify the "haves" from the "have nots."²⁸ However, those who do not oppose the trend to expand Good Samaritan acts respond to this criticism by pointing out that lofty ideals regarding equality are one thing, and getting care to those who need it now is quite another. One advocate espousing that notion is also quick to note that she believes that those supporting the new legislation in the District of Columbia, the Medical Society and the American Tort Reform Association, are not simply interested in serving the health care needs of the poor; instead, they are concerned with furthering their own tort reform agenda.²⁹

Consequently, there is not a consensus among these groups regarding the efforts to grant immunity to those who treat the poor. Although no one is entirely comfortable with the idea of relinquishing the right to sue in exchange for access to health care, some feel it is a trade-off worth making. As data become available regarding the efficacy of such policies like the one in the District of Columbia, these groups will likely become more vocal in their support or opposition to the trend to expand Good Samaritan laws.

IV. TORT REFORM

Poor as Plaintiffs

Using Good Samaritan acts as instruments of tort reform implies that the poor are increased liability risks. Poor patients, however, contrary to widely-held misconceptions among physicians, are not more likely, or even as likely, as middle-class or privately insured patients to sue.³⁰ In fact, studies have repeatedly shown that victims of malpractice who are poor rarely pursue their right to compensation in court.³¹ This myth has no grounding in fact for several reasons. First of all, many poor persons lack sophistication regarding the judicial system and do not have access to legal assistance. The primary providers of legal assistance to the poor, legal

28. Telephone Interview with Frank Trinity, Washington Legal Clinic for the Homeless, Washington D.C. (Apr. 17, 1992); interview with Lydia Williams, *supra* note 25.

29. Interview with Renee Wallis, *supra* note 27.

30. Molly McNulty, *Are Poor Patients Likely to Sue for Malpractice?*, 262 JAMA 1391 (1989); *see also* Rosenbaum, *supra* note 13, at 235-236.

31. [S]tudies reinforce what logic tells us: for a variety of reasons, poor people are the most unlikely patients to sue. The primary reason is that the poor are even less likely than the general population to perceive that any type of wrong has occurred or to assert their rights, and much less likely to obtain legal counsel.

McNulty, *supra* 30, at 1391; *See also* Rostow, et al., *supra* note 11, at 1058.

aid clinics, do not handle malpractice cases. A poor person's ability to retain a private attorney on a contingency fee basis will be diminished because of the limited amount of recovery likely for someone with no, or limited, earning power, as this will impact on the amount of recovery possible.³² Additionally, under some government subsidized health care programs, if a recipient receives a major award as a result of a malpractice claim, he or she is required to turn over the award to the state, to the extent that the state paid for his or her care.³³

The myth concerning the litigiousness of the poor is further debunked by a study conducted by physicians at the University of California, San Diego, which reviewed the hospital records of all obstetrical patients who initiated lawsuits at the Medical Center from 1982 through 1988.³⁴ The obstetrical patients initiating suits were compared to the obstetrical admissions generally. The patients were divided into three categories: those receiving public funding, those with private insurance, and those affiliated with a health maintenance organization ("HMO"). Although the HMO patients sued in proportion to the number of HMO patients admitted, the patients with private insurance were twice as likely to sue, and the patients receiving public funding were one-third less likely to sue than expected.³⁵ The authors of the study concluded that women with private insurance file lawsuits more frequently than women receiving publicly subsidized health care.³⁶

Real or Imagined Impact

The amendment of Good Samaritan acts to provide health care services to the poor constitutes tort reform in a defined segment of the overall existing system. If, however, this patient population does not pose a significant liability threat to providers, then this type of reform will fail to bring about significant change. On the other hand, some states are undertaking more systemic tort reform measures to reduce health care costs across the board and to increase access to care.³⁷ To date, most state reform has included

32. McNulty, *supra* note 30.

33. Rosenbaum, *supra* note 13, at 238.

34. Thomas R. Moore & Robert T. Andrews, *Differential Litigiousness Among Obstetric Patients by Payor Source*, 164 AM. J. OBSTETRICS & GYNECOLOGY 327 (1990).

35. *Id.*

36. *Id.*

37. For example, in 1975, California enacted the Medical Injury and Compensation Reform Act ("MICRA"). Under MICRA, the existing court system is used for malpractice litigation; however the following reforms have been instituted: (1) a \$250,000 cap on noneconomic damages; (2) a sliding scale for attorneys' contingency fees (the higher the

attention to the following areas: statutes of limitation, screening panels for medical malpractice cases, limits on attorney contingency fees, modification of joint and several liability rules, caps on recoveries, revision of the collateral source rule, limitations on punitive damages, and structured payments of awards.³⁸

Although tort reform has been traditionally treated as a state, rather than federal, issue, the federal government is increasingly interested in developing tort reform on a national level.³⁹ The federal government's interest is a result of the considerable sums of federal dollars spent on health care. The federal government has attempted to address cost issues through cost containment, reducing the costs of defensive medicine, and changing the medical malpractice litigation process.⁴⁰ However, at this time a consensus is lacking at the federal level regarding the method or manner of implementing broad-based tort reform. For this reason, for the foreseeable future the action in tort reform will remain with the states.

Increased liability insurance costs have driven the call for tort reform. Without reform many fear that premium costs will continue on an upward spiral; insurance companies will argue that million dollar malpractice judgments, and the specter of their multiplying, require higher liability premiums, and physicians will pass on the costs of higher premiums to individual patients, employers, and government payors. To many, this situation forecasts a hopeless cause and effect reaction.

Tort reform may be an inevitable and necessary answer to many of the problems in our present health care system. However, the issue is not whether tort reform would benefit the system, but rather, whether amending Good Samaritan acts constitutes serious tort reform. Whether the legislation contemplated here accomplishes meaningful reform and achieves legislators' avowed objectives remains an unanswered question. Although it is probably too soon to accurately assess whether these measures will have much

award, the lower the percentage of the total award the attorney is entitled to); (3) a collateral source offset rule that permits juries to know of payments that a plaintiff is already receiving for an injury; and (4) periodic payments of the damage award is permitted instead of lump sum payment. Teresa Hudson, *Tort Reform Legislation: Can it Help Hospitals?*, HOSPS., May 20, 1990, at 28, 32-33.

38. Mitchell J. Wiet, *Medical Malpractice Tort Reform: Balancing the Interests of Providers, Patients and Public*, 10 AM. J. OTOLGY 208, 209-210 (1989).

39. See Hatlie, *supra* note 17; Hudson, *supra* note 37, at 28-31.

40. Hudson, *supra* note 37, at 28-29.

impact, it will be necessary to consider the objectives sought and evaluate whether they are achieved.

The objectives of amended Good Samaritan acts are to increase access through volunteerism, thereby reducing costs for medical care to the public, and to help insurers limit exposure to claims by preventing those who receive free care from suing for negligence. Prior to undertaking tort reform through expanding their Good Samaritan laws, states must determine whether there is evidence that access will be appreciably increased and the incidence of claims decreased by expanding the coverage of these laws as proposed.

Furthermore, before developing a system dependent upon volunteers, policymakers must consider the appropriateness of shifting the responsibility of caring for the poor from the government to health care providers. The fundamental fairness to health care providers and their willingness to undertake this responsibility must be established.⁴¹ Although the promotion of volunteerism is a sound societal objective, fulfilling this goal could potentially turn into a weighty burden for medical professionals.

States must also be ready to address questions about continuity of care and quality of care under a volunteer system. With the volunteer model it may be difficult to maintain the same type of quality controls that non-volunteer providers maintain. This is not to say that the care provided by volunteers is per se of a lesser quality, but rather that a system solely dependent upon volunteers may experience problems because of the very nature of volunteer organizations, as opposed to providers who are paid to furnish their services. There are examples of clinics that function mostly on volunteer workers, but they also employ paid staff members as well, including executive directors, staff physicians, nurses, and social workers. Therefore, volunteer systems can succeed, but it helps to have a core of paid employees, and it is necessary to have competent volunteers willing to render their services. By making this work a volunteer's responsibility, the government is relieved of the responsibility for providing care for needy citizens. To some,

41. At the June 1992 Meeting of the American Medical Association ("AMA"), the AMA House of Delegates defeated a proposal that would have made free care for the poor part of a doctor's ethical duty. However, delegates did pass a resolution stating AMA policy supports care for the poor. Janice Perrone, *Charity Care Quota Not Ethical Duty, House Decides*, AM. MED. NEWS, July 6/13, 1992, at 4. This suggests that physician willingness to volunteer must be clearly established prior to creating policy based on the assumption that there will be sufficient numbers of willing volunteers.

this may amount to an unacceptable abdication of responsibility by the government.

States should also ascertain whether there is evidence that overall costs for medical care to the public have decreased in jurisdictions that have expanded the coverage of their Good Samaritan laws. Lastly, it is conceivable that a measure such as expanding the coverage of these acts will limit insurers' exposure to claims; however, the government will hardly have achieved its purposes if the result of this policy is to simply shift costs that formerly may have fallen upon insurers to other payors.

Even if it is too soon to gauge the impact of expanded coverage Good Samaritan acts on these issues, it is not too soon for states contemplating this policy to thoroughly evaluate the rationales underlying these efforts and determine whether they ought to be given an opportunity to be tested through enactment in their own legislatures.

Other Options

There are additional means of addressing the problems associated with access that take into account some of the shortcomings inherent in the movement to expand Good Samaritan laws. One such means is for states to provide premium subsidies to those physicians rendering medical care to the poor. For instance, the states of Arizona, Hawaii, and Florida provide a premium subsidy for practitioners who agree to provide obstetrical care in underserved areas.⁴² This approach is used to either maintain or increase the provision of services where they are most needed. Missouri and Kansas developed another means of broadening access; the state governments entered into employment contracts with physicians who thereby became state employees to provide care to the indigent.⁴³ Under this model, a patient can sue for negligent care, but the physician/state employees can be sued only to the extent permitted by the state tort claims act. Yet another alternative, in effect in Florida and Virginia, concerns the operation of no-fault compensation funds for neurological birth-related injuries.⁴⁴ These systems provide an alternative to the tort system for a specifically

42. Arizona and Hawaii's premium subsidies are part of annual appropriations from their legislatures and are not statutory, while Nevada's subsidy exists in its statute. NEV. REV. STAT. ANN. § 442.1192 (Michie 1991).

43. See MO. ANN. STAT. § 105.711 (Vernon Supp. 1992); KAN. STAT. ANN. § 75-6102 (1989 & Supp. 1991).

44. See FLA. STAT. ANN. § 766.303 (West Supp. 1992); VA. CODE ANN. § 38.2-5000 (Michie 1990).

defined type of injury. Under these fund programs, the injured party receives compensation for economic losses in a timely manner, but it is the exclusive remedy available.

The common thread between these options is the provision of some form of remedy for the poor if they receive substandard health care. For this reason, they are more acceptable and would likely survive constitutional challenge. Furthermore, under these options the responsibility for providing health care services to the poor does not fall disproportionately upon health care provider volunteers, and the government retains a level of responsibility to the health care needs of the poor. These options are preferable to the amended Good Samaritan acts, and are more appropriate means of addressing the problem of access.

V. CONCLUSION

Manipulation of the Good Samaritan Doctrine

As Good Samaritan acts are of questionable effectiveness to begin with, it follows that they should not constitute the foundation for further policy. Moreover, the original intent of these acts concerned the provision of uncompensated emergency care at the site of an emergency. In an effort to encourage the provision of emergency road-side care, legislators determined that it was appropriate to extend the rescuers immunity for their negligent acts. This dated and unproven hypothesis should not form the bedrock for modern health policy for the poor.

Assuming it is reasonable to require the poor to relinquish their ability to sue for negligent care in exchange for access to health care, then this policy should be examined and justified on its own merits, and not presumed to be legitimate because it is appended to agreeable sounding, but ineffectual, Good Samaritan laws.⁴⁵ Therefore, prior to taking this route, policymakers must first fully assess the origins of the access problem and address the sum total of the issue, rather than focusing narrowly on liability as the source of the access crisis. The movement to amend Good Samaritan acts to provide immunity for physicians providing care to the indigent assumes that liability issues are wholly responsible for the crisis in access and ignores additional contributing factors.

45. Some states have passed laws, independent of their Good Samaritan acts, that provide immunity for those providing health care services for the poor. See ILL. ANN. STAT. ch. 111, para. 4400-31 (Smith-Hurd Supp. 1991); N.D. CENT. CODE § 32-03.1-02.2 (Supp. 1991); S.C. CODE ANN. § 33-55-210(B) (Law. Co-op. 1990); VA. CODE ANN. § 54.1-106 (Michie 1991).

In the future, states should refrain from using their Good Samaritan acts to create access to health care until there is evidence to establish that these amended laws actually improve access, reduce costs, or significantly reduce claims. Attention should be paid to the alternatives to amending Good Samaritan laws mentioned above, which reflect a more acceptable policy in a time of contracting access and expanding costs of health care. What sets these options apart from the amended Good Samaritan legislation is the provision of a remedy, albeit often a limited one, for persons dependent upon the government for the provision of health care and who receive negligent services. The provision of premium subsidies, the provision of indemnity, or the provision of a liability compensation pool at least guarantees some recourse for the most economically disadvantaged when they receive substandard care. These alternatives are preferable to the Good Samaritan amendments, which eliminate a poor person's ability to seek legal redress for negligent care.

