GOOD SAMARITAN STATUTES: A SUMMARY AND ANALYSIS

MITCHELL McINNES†

I. INTRODUCTION

When asked by a teacher of law what must be done to inherit eternal life, Jesus responded with the parable of the Good Samaritan.[1]

> A man was going down from Jerusalem to Jericho, when he fell into the hands of robbers. They stripped him of his clothes, beat him and went away, leaving him half dead. A priest happened to be going down the same road, and when he saw the man, he passed on the other side. So too, a Levite, when he came to the place and saw him, passed by the other side. But a Samaritan, as he travelled, came to where the man was; and when he saw him, he took pity on him. He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his own donkey, took him to an inn and took care of him . . .

For the most part, the law has not joined with Christian teaching in promoting compassion and encouraging emergency intervention. Unless exceptional circumstances prevail, the priest's and the Levite's behaviour, while morally reprehensible, is beyond the reproach of our system of common law.[2] Furthermore, the Samaritan could be held liable if his attempt to provide relief exacerbated existing injuries or

† This article is based on doctoral research conducted at Trinity Hall, Cambridge University under the supervision of Mr. Andrew Tettenborn. It was written with the support of a fellowship from the Social Sciences and Humanities Research Council of Canada. I would like to thank Ms Alison Hughes for her insightful comments.

1 Luke 10: 25-34.

2 For a discussion of the situations in which liability may lie for a failure to rescue in the common law jurisdictions, see M. McInnes, "The Question of a Duty to Rescue in Canadian Tort Law" (1990) 13 Dalhousie L.J. 85.

In Quebec, the *Charter of Human Rights and Freedoms* (R.S.Q. 1977, c. C-12, s. 2) contains a general duty to rescue. For an excellent discussion of the law in that province, see S. Rodgers-Magnet, "The Right to Emergency Medical Assistance in the Province of Quebec" (1980) 40 R. de B. 373.

inflicted new ones.[3] In recent years, however, legislators in most Canadian jurisdictions, believing the latter common law rule to be undesirable, have enacted what have come to be known as "Good Samaritan statutes."[4] This article will examine those statutes.

The purpose of the Good Samaritan laws is clear.[5] Legislators have tried to encourage more people, especially those with medical training, to provide assistance to individuals rendered ill, injured, or unconscious by an accident or emergency. According to legislative theory, potential rescuers often withhold their services for fear that well-intentioned but imperfect efforts could lead to liability; intervention will increase if that fear can be assuaged. Hence, Good Samaritan statutes grant a partial immunity from liability by typically[6] providing that rescuers will only be held accountable for injuries or fatalities that they cause through "gross negligence."

The discussion that follows will be divided into two parts. First, the reasons for the enactment of the Good Samaritan laws will be examined. As will be seen, the actual risk of liability faced by rescuers under the common law is minimal. That is not to say, however, that the statutes are necessarily unwarranted; they may be justified on the basis that potential rescuers are inhibited by the perception of a risk of liability. In the second part of the discussion, the statutes' provisions will be analyzed in detail. Superficially simple and innocuous, a closer examination reveals that they are, in fact, rife with ambiguities and illogicalities, and are capable of producing what would arguably be unfair and unintended results.

---

3 See J.G. Fleming, *The Law of Torts*, 7th ed.(Sydney: Law Book Company, 1987) at 135.

4 Other common law rules have similarly been modified over the years to provide more encouragement to potential rescuers. For example, the courts no longer rely on the concepts of causation (*Anderson v. Northern Ry. Co.* (1875) 25 U.C.C.P. 301 (C.A.)), or *volenti* (*Kimball v. Butler Bros.* (1910) 15 O.W.R. 221 (C.A.)) to routinely deny compensation to rescuers who are injured in the course of rescuing a person from a negligently created peril. Furthermore, in some situations, a rescuer will now be able to receive compensation for the services he provides: *Matheson v. Smiley* [1932] 2 D.L.R. 787, [1932] 1 W.W.R. 758 (Man. C.A.). And, of course, the situations in which a bystander will be required to provide assistance have increased significantly in recent years: see McInnes, *supra*, note 2.

5 See generally *Debates and Proceedings of the Legislative Assembly of Saskatchewan*, 2nd Session, 18th Legislature (1976) at 1513-4; *Debates of the Legislative Assembly of British Columbia*, 3rd Session, 31st Parliament (1978) at 2498; *Debates and Proceedings of the Yukon Legislative Assembly*, 7th Session, 23rd Legislature (1976) at 30; *Nova Scotia House of Assembly Debates and Proceedings*, 51st General Assembly, 4th Session (1977) at 1273.

6 Seven of the eight Good Samaritan statutes in Canada employ the gross negligence concept. In Prince Edward Island, physicians and surgeons are liable only for injuries or fatalities that they cause by actions which, "if committed by a person of ordinary experience, learning and skill, would constitute negligence": *Medical Act*, R.S.P.E.I. 1988, c. M-5, s. 50. The issue of the standard of care applicable in emergency situations is examined *infra* at Section III(E).

II. IS THERE A NEED FOR GOOD SAMARITAN LEGISLATION?

The first Good Samaritan legislation appeared in California in 1959.[7] Within five years, a majority of the American states had enacted similar laws,[8] and today there are over one hundred and ten statutes providing some form of immunity to rescuers in all fifty states, as well as in the District of Columbia.[9] A comparable though less pronounced development has occurred in this country. By 1966, the idea of the Good Samaritan statute had drifted north of the border, and the *Medical Act* of British Columbia was amended to protect physicians and surgeons who provided emergency assistance.[10] In 1969, Alberta became the first jurisdiction in Canada to have a Good Samaritan statute applicable to both medically trained and non-medically trained rescuers when its provincial legislature passed the *Emergency Medical Aid Act*.[11] Since that time, four other provinces and both territories have followed suit: Newfoundland (1971),[12] Saskatchewan (1976),[13] the Yukon (1976),[14] the Northwest Territories (1976),[15] Nova Scotia (1977),[16] and British Columbia (1978).[17] Since 1978, physicians and surgeons rendering emergency treatment in Prince Edward Island have also enjoyed protection.[18]

Given the proliferation of statutes, it might be assumed that there is (or at least was) a pressing social need for Good Samaritan laws. Curiously, however, in at least three of the four provinces in which legislation has not been enacted, Good Samaritan proposals have been expressly rejected as being otiose.[19] In 1964, the government of Quebec declined the invitation of the Collège des Médecins to introduce a new

---

7 1959 Cal. Stat. 1507 (currently codified, as amended, at CAL. BUS. & PROF. CODE 2395 (West Supp. 1987)).

8 See L. Holland, "The Good Samaritan Laws: A Reappraisal" (1967) 16 J. of Pub. L. 128 at 130-1.

9 Citations for all of the American statutes are given in R. Mason, "Good Samaritan Laws-Legal Disarray: An Update" (1987) 38 Mercer L. Rev. 1439 at 1461-74.

10 *Medical Amendment Act*, S.B.C. 1966, c. 26, s. 48.

11 S.A. 1969, c. 28 (now *Emergency Medical Aid Act*, R.S.A. 1980, c. E-9).

12 *Emergency Medical Aid Act*, S.N. 1971, No. 15.

13 *Emergency Medical Aid Act*, R.S.S. 1978, c. E-8.

14 *Emergency Medical Aid Act*, R.S.Y. 1986, c. 52.

15 *Emergency Medical Aid Act*, R.S.N.W.T. 1988, c. E-4.

16 *Volunteer Services Act*, R.S.N.S. 1989, c. 497.

17 *Good Samaritan Act*, R.S.B.C. 1979, c. 155 (repealing *Medical Act* R.S.B.C. 1960, c. 239, s. 82(2)).

18 *Medical Act*, R.S.P.E.I. 1988, c. M-5, s. 50.

19 I have been unable to uncover any information concerning Good Samaritan legislation in New Brunswick.

statute, or to amend the provincial *Medical Act*, for that reason.[20] In 1970 and 1971, the Ontario Law Reform Commission argued against the enactment of Good Samaritan legislation on similar grounds,[21] and in 1984 a members' bill introduced in the Ontario Legislative Assembly died after first reading.[22] Finally, the Manitoba Legislature followed the recommendation of that province's Law Reform Commission, which studied the matter in 1973 and concluded that legislation was not needed.[23] The decisions made in Quebec, Ontario, and Manitoba raise the possibility that the Good Samaritan statutes of eight other jurisdictions serve no significant function.

A. The Good Samaritan in the Courts

A survey of case law does not reveal a pressing need for the legislation; prior to the enactment of the Good Samaritan statutes, there does not appear to have been a single reported decision involving a suit successfully brought against a rescuer.[24] Furthermore, although most have been in force for over fifteen years, only three of the statutes have received judicial consideration.[25] In *Re Osinchuk*,[26] the Alberta Surrogate Court discussed a since-repealed section of that province's *Emergency Medical Aid Act* in a non-emergency context.

Nova Scotia's *Volunteer Services Act*, which applies to the rescue of property,[27] as well as of people, was considered in dicta in *Nelson* v.

---

20 A. Roy, "Deuxième Colloque de Responsabilité civile comparée: La médicine et la droit: Nouveaux aspects de la responsabilité civile médicale" [1975] R.J.T. 33.

21 *Fourth Annual Report* (1970) at 13; *Fifth Annual Report* (1971) at 13.

22 Bill 98, *Good Samaritan Act*, 1984.

23 *Report on the Advisability of a Good Samaritan Law in Manitoba*, Report #11 (1973) at 9-10.

24 See Dean Wilbur F. Bowker's comments in *Report on the Advisability of a Good Samaritan Law in Manitoba*, *ibid.* at 8. Dicta to the effect that liability is possible can be found in a number of decisions: e.g. *Horsley* v. *McLaren* (1970) 11 D.L.R. 277 at 285 (*per* Schroeder J.A.), 290 (*per* Jessup J.A.).

25 The history of the American legislation has been slightly different. There is a paucity of case law pre-dating the enactment of the first statute in 1959: see F. Mapel & C. Weigel, "Good Samaritan Laws-Who Needs Them?: The Current State of Good Samaritan Protection in the United States" (1981) 21 S. Texas L.J. 327 at 330. While the amount of litigation taken under the statutes was minimal at first, it has been on the rise in recent years. By 1990, approximately 45 decisions had been rendered which mentioned (but did not necessarily rely on) the Good Samaritan laws: see R. Mason, "Good Samaritan Laws-Legal Disarray: An Update" *supra*, note 9 at 1443; 68 A.L.R. 4th at 294ff.

26 (1983) 45 (A.R.) 132 at 144. The section (repealed R.S.A. 1980, c. 7 (Supp.), s. 1) empowered physicians and dentists to examine and treat those incapable of giving their consent if the procedure to be performed was considered necessary in the written opinion of two other physicians or dentists.

27 The act is unique in Canada in extending an immunity to those who attempt to rescue property, whether real or personal: *Volunteer Services Act*, *supra*, note 16 at s. 4.

Victoria County (Municipality).[28] The plaintiffs, whose home was destroyed by a fire, brought a suit against several parties, including a local volunteer fire department and several members of that organization. It was alleged that the defendants had negligently failed to respond in a timely manner to a call for assistance. Mr. Justice Nathanson held that while the defendants, as volunteers, were not initially under a duty to battle the blaze, they became obligated to conduct themselves reasonably and without negligence once they had begun to act.[29] He found that the obligation had been fulfilled. Moreover, Nathanson J. decided that, at least in the case of the individuals who had been personally named in the action, ordinary negligence would not have been sufficient to ground liability;[30] because the *Volunteer Services Act* applied, only gross negligence would have run afoul of the standard of care.

Finally, the *Good Samaritan Act* of British Columbia was considered in *Fraser* v. *Kelowna Motorcycle Club,*[31] a case involving a ten year old boy who sustained severe brain damage after losing control of his motorcycle during an organized race. The child brought an action against St. John Ambulance and two of its volunteer attendants, alleging that they had been negligent in diagnosing and treating his injuries. Macdonell J. rejected the plaintiff's contention, and found that the child was himself solely responsible for the injuries that he suffered. The Justice further held, in dicta, that the attendants could not have been held liable even if they had acted negligently; since their actions fell within the purview of the act, anything less than gross negligence was excusable.

The dearth of cases involving negligent rescuers may be explicable on several grounds. Most obviously, the factual elements required for a suit probably do not come together very frequently. On those exceptional occasions when a need for rescue does arise, it may be ignored, or it may be successfully met; in either case, legal proceedings will not ensue. Furthermore, even when assistance is improperly rendered and causes harm, the victim may not pursue a claim. He may be unaware of his legal rights, he may not want to become caught up in the litigation process, he

---

28 (1987) 203 A.P.R. 334, 81 N.S.R. (2d) 334 (N.S.S.C. T.D.).

29 A gratuitous undertaking will give rise to liability only if the rescuer's efforts detrimentally affect the victim: see e.g. *East Suffolk Rivers Catchment Bd.* v. *Kent* [1940] 4 All E.R. 527 (H.L.); *H.R. Moch Co.* v. *Rensselaer Water Co.* 159 N.E. 896 (N.Y.C.A. 1928); L. Klar, *Tort Law* (Toronto: Carswell, 1991) at 142-3.

30 While the matter is not discussed in the decision, Nathanson J. undoubtedly would have refused to apply the statute in favour of the fire department because the act refers only to "individuals" who voluntarily render services or assistance.

31 (26 February 1988) Vancouver No. C826791 (B.C.S.C.).

may have recourse to other sources of compensation, or he may not wish to appear ungrateful.

A number of factors inherent in the Canadian system of tort law also limit the ability of victims to succeed in actions against rescuers. First, even in the absence of Good Samaritan legislation, the degree of care that rescuers are expected to exercise is not particularly great. A basic proposition in tort law is that one must act as a reasonable person would act in like circumstances. A corollary of that rule is the "sudden peril" doctrine, which holds that a person confronted with an emergency will not be required to exhibit the level of prudence and competence that would be demanded in less stressful situations.[32] Errors in judgment or execution that could normally give rise to liability will be excused to the extent that they are justified by the facts of a case.[33]

The realities of the litigation process further militate against the successful prosecution of claims against doctors.[34] In such cases, the difficulties involved in marshalling proof of negligence (or of gross negligence where legislation is in place) will often be exacerbated. Since the standard of care that must be met by a doctor is that of a reasonably prudent practitioner in like circumstances, a plaintiff will typically find it necessary to adduce expert evidence from another doctor in order to establish the defendant's breach of duty. The reluctance of doctors to testify against one another can complicate that task considerably.[35]

Finally, the chilling effects of the foregoing factors are amplified by the relative infrequency with which lawyers in Canada are willing and able to work on a contingency fee basis.[36] One who wishes to sue a

---

32 E.g. *C.P. Ltd.* v. *Gill* [1973] S.C.R. 654. The "sudden peril" doctrine is not applicable in regards to emergencies that one has had a hand in creating, or that one ought to have foreseen. For a discussion of the doctrine, and for citations to the leading cases, see Klar, *supra*, note 29 at 220-1.

33 It appears that some legislators enacted Good Samaritan statutes in ignorance of the sudden peril doctrine: e.g. *Nova Scotia House of Assembly Debates and Proceedings*, *supra*, note 5 at 1273.

34 While the protection provided by most Good Samaritan statutes is available to all rescuers, it is clear that legislators have been especially concerned with the possibility that physicians who render emergency assistance might be subject to litigation: *Debates and Proceedings of the Legislative Assembly of Saskatchewan*, *supra*, note 5 at 1513; *Nova Scotia House of Assembly Debates and Proceedings*, *supra*, note 5 at 1273; *Debates and Proceedings of the Yukon Legislative Assembly*, *supra*, note 5 at 30. In Prince Edward Island, it is only physicians who are granted a statutory immunity.

In theory, at least, it may be that physicians are particularly vulnerable to the danger of being sued. That possibility is explored in the next section.

35 The reluctance of doctors to testify against one another has often been labelled the "conspiracy of silence"; however, as noted by Professor Picard (as she then was), there are many explanations underlying the phenomenon, only some of which are conspiratorial in nature: E. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 2d ed. (Toronto: Carswell, 1984) at 270-3.

36 Ontario is now the only province in which contingency fees are not officially permitted; and even in that province, they are occasionally employed in practice, if not in name: M.

rescuer may find it difficult to secure capable representation for what would be a difficult and even speculative action.[37]

B. The Good Samaritan and the Problem of Perception

The infrequency with which rescuers have been sued, and the difficulties that would confront a victim who brought an action, strongly suggest that Good Samaritan statutes are unnecessary. In some cases, however, the perception of a threat may be as troublesome as an actual threat. Is it true, as some have argued, that while "the danger is imaginary . . . the fear [is] quite real"?[38] Are potential rescuers dissuaded from providing emergency relief by the erroneous belief that intervention entails a significant risk of liability? If so, Good Samaritan legislation may be warranted after all.

A number of studies have examined the extent to which the fear of liability inhibits the provision of emergency assistance by physicians. Between a third and a half of the American doctors who have been surveyed admitted that they would not stop to render aid, usually because of a fear of malpractice litigation.[39] Somewhat surprisingly, in a 1971 survey of approximately 2000 Ontario doctors, less than 9% of those questioned indicated that they would not attempt to provide relief in an emergency.[40] When the same individuals were asked to explain why some doctors might not want to become involved, half cited the fear

---

Trebilcock, "The Case for Contingency Fees: The Ontario Legal Profession Rethinks its Position" (1989) 15 Can. Bus. L.J. 360. It appears, however, that contingency fees are commonly used only in Alberta and British Columbia: Lawyers' Weekly 8 July 1988, 1. See also W. Williston, "The Contingent Fee in Canada" (1968) 6 Alta. L. Rev. 184; H. Kritzer, "Fee Arrangements and Fee Shifting: Lessons From the Experience in Ontario" (1984) 47 Law & Contem. Prob. 125.

37 The number of actions taken under the American Good Samaritan statutes (*supra*, note 25) is likely, in part, a function of the degree to which the American tort system encourages litigation, for example, through the prevalent use of contingency fees and through the use of the "American rule" (as opposed to the "fee-shifting rule") of costs. For a discussion of the impact that contingency fees and the American costs rule have had in the United States, see J.G. Fleming, *The American Tort Process* (Oxford: Oxford University Press, 1990) at 195-205, c. 6.

38 *Debates and Proceedings of the Legislative Assembly of British Columbia, supra*, note 5 at 2498 (*per* Hon. Mr. Gardom).

39 In a 1961 survey conducted by the Medical Tribune, and reported in *Newsweek* 4 September 1961, approximately 50% of the 1200 doctors questioned indicated that they would not provide emergency care. Similar figures were obtained in a 1964 survey of 7500 doctors conducted by the American Medical Association: (1964) 189 J.A.M.A. 863. A study of 130 Florida doctors found that approximately 33% would refuse to intervene: (1965) 17 Fla. L. Rev. 586. Finally, a study that asked theatre going physicians if they would respond to a call for "a doctor in the house" found that 41% would not respond unless they knew the nature of the emergency, 14% would respond only if no other doctor did, and 16% said they would not respond under any circumstances: T. Flowers & W. Kennedy, "Good Samaritan Legislation: An Analysis and a Proposal" (1965) 38 Temple L.Q. 418 at 419.

40 R. Gray & G. Sharpe, "Doctors, Samaritans and the Accident Victim" (1973) 11 Osgoode Hall L.J. 1.

of legal action. The startling contrast between the figures obtained in the American surveys and those obtained in the Canadian survey have been explained on a number of bases, ranging from a "social and cultural gap" between Americans and Canadians, to differences in the litigation systems of the two countries.[41]

Though more recent data would certainly be welcome, the results of the Ontario survey do suggest that Good Samaritan legislation may not be needed in this country.[42] That suggestion is further supported by the findings of the Manitoba Law Reform Commission, which canvassed the views of a number of groups in preparing its *Report on the Advisability of a Good Samaritan Law in Manitoba.*[43] The Canadian Medical Protective Association, a mutual defence union of doctors, noted the lack of case law on point, expressed its confidence in the judiciary's ability to render impartial and realistic judgments, and argued that much of the impetus behind the move towards statutory protection was the product of "the great but undue influence of American medico-legal literature on Canadian doctors."[44] In the opinion of the Association, legislation was not needed. The same conclusion was reached by, among others, the College of Physicians and Surgeons of Manitoba, the Manitoba Medical Association, and the Manitoba Association of Registered Nurses.[45] Other professional groups have advocated the implementation of legislation, but have not offered much evidence in support of their position.[46] On the whole, it appears that the weight of data and opinion

---

41 *Ibid.* at 2, 25. As to the latter explanation, the authors of the Canadian study cite the extent to which the Canadian legal system, as compared with its American counterpart, discourages speculative litigation by awarding more generous costs against a losing party, and by prohibiting the use of contingency fee arrangements in some jurisdictions: *ibid.* at note 5. Since the study was conducted, contingency fees have become more accepted, but not significantly more prevalent, in Canada: *supra,* note 36.

42 Indeed, many American commentators who have studied the matter have suggested that Good Samaritan laws are not needed in their country either: *cf.* S. Hessel, "Good Samaritan Laws: Bad Legislation" (1974) 2 J. Leg. Med. 40; Mason, *supra,* note 9; E. Brandt, "Good Samaritan Laws-The Legal Placebo: A Current Analysis" (1983) 17 Akron L. Rev. 301; Mapel & Weigel, *supra,* note 25.

43 *Supra,* note 23.

44 *Ibid.* at 4. Somewhat curiously, the Legislative Assembly of the Yukon felt that a Good Samaritan statute was warranted despite the fact that doctors in that jurisdiction did not feel that legislation was needed: *Debates and Proceedings of the Yukon Legislative Assembly, supra,* note 5 at 32.

45 *Report on the Advisability of a Good Samaritan Law in Manitoba, supra,* note 23. A number of groups contacted by the Law Reform Commission did, however, support the enactment of legislation, among them the St. John Ambulance Council of Manitoba and the Winnipeg Fire Fighters Association.

46 Among those groups that have supported the enactment of Good Samaritan laws have been the College of Physicians and Surgeons of Saskatchewan, the Special Committee of the Saskatchewan Legislature on Highway Traffic and Safety (*Debates and Proceedings of the Legislative*

tends to accord with the Ontario Law Reform Commission's assertion that this country's Good Samaritan statutes are an example of "finding false Canadian social problems to fit real American solutions."[47]

One American study even suggests (albeit very weakly) that the introduction of Good Samaritan legislation may actually have a detrimental affect. Physicians were asked, both before and after legislation had been enacted in the states in which they were practising, whether they would stop at the scene of an accident and provide assistance. Prior to the introduction of the statutes, 50% responded in the affirmative; after the statutes had been enacted, only 49% responded in the affirmative. Not only did the legislation fail to increase the number of physicians willing to intervene, it may have even further inhibited the provision of aid.[48]

Those paradoxical results may be explained in a number of ways. First, it may be that a vague awareness of Good Samaritan laws alerts people to the issue of liability without going on to assuage the fear of it. That possibility finds some support in a survey of American physicians and medical students which found that, while the existence of Good Samaritan statutes was a matter of common knowledge, the scope of protection offered by those statutes was a matter of some confusion.[49]

Assembly of Saskatchewan, supra, note 5), and the Registered Nurses Association of British Columbia. The last mentioned group's support arose out of a single incident during which twelve people watched a young man die after two of the bystanders advised the others to not become involved: *Debates of the Legislative Assembly of British Columbia, supra,* note 5.

47 *Fourth Annual Report, supra,* note 21 at 14. It should be noted, however, that the evidence which does exist is several years old. It may be that the recent "insurance crisis" provides new justification for the Good Samaritan statutes. Many emergency relief organizations, such as St. John Ambulance, are finding it increasingly difficult to afford liability insurance: *Final Report of the Ontario Task Force on Insurance* (Toronto: Ministry of Financial Institutions, May 1986) at 34. (D. W. Slater, Chairman) [*The Slater Report*]. The retention or introduction of Good Samaritan legislation may help to assuage the anxiety of the insurance industry, and to facilitate the continued existence of relief organizations.

48 N. Chayet, "This Summer in Samaria" (1971) 3 Emerg. Med. 161 at 163. Another study worth noting found that the number of doctors in states without legislation that were willing to intervene (52.3%) was slightly higher than the number of doctors in states with legislation that were willing to intervene (48.5%): N. Chayet, *The Legal Implications of Emergency Care* (New York: A.C.C., 1969) at 36.

It should be noted that the data obtained in the two studies may no longer be reliable. The views of American physicians twenty and thirty years ago may not be representative of attitudes more broadly held by Canadians today. Indeed, the 1971 survey of Ontario physicians discussed earlier (*supra,* note 40) strongly suggests that members of the medical communities on either side of the border did not share the same beliefs even when the Good Samaritan surveys were conducted.

49 Approximately 85% of the New York medical students and physicians who participated in a 1974 survey knew whether or not legislation had been enacted in their home state. However, when the same group was presented with a series of true-false questions concerning the scope of Good Samaritan statutes generally, correct responses were given only 59% of the time, a figure only marginally better than that which would have been produced by chance alone: Hessel, *supra,* note 42.

Such uncertainty may breed caution and inhibition. Second, it may be that the physicians were unaware of the legislation, and hence incapable of being affected by it.[50] Finally, as seems most probable, it may be that the data pertaining to the change in the attitudes of the physicians is not significant, and that the Good Samaritan laws were behaviourally irrelevant.

It is possible that Good Samaritan statutes may have other deleterious effects. Fears have been expressed that such laws "encourage kindly but untrained persons to accord inappropriate or dangerous treatment to the ill."[51] Furthermore, the statutes, which were introduced to reduce the amount of litigation taken against rescuers, may eventually increase the number of lawsuits. As noted above, rescuers were seldom, if ever, sued in either Canada or the United States prior to the enactment of legislation.[52] Although a similar development has yet to take root in this country, it seems that the existence of Good Samaritan statutes may have sown the seeds of dispute south of the border. The fact that American rescuers are now more apt to be sued[53] is undoubtedly attributable to many factors, some of which may not hold true in Canada.[54] It is possible, however, that the mere existence of the statutes has contributed to the escalating number of actions taken in the United States. If so, one may anticipate that, in time, Canadian courts may also be called upon to hear such matters more frequently. For those who

---

50 It is not clear whether the individuals who had participated in the survey had been apprised of their legal rights: Chayet, *supra*, note 48.

51 That concern was expressed by a number of police departments when asked by the Law Reform Commission of Manitoba for their views regarding legislation: *Report on the Advisability of Good Samaritan Law in Manitoba*, *supra*, note 23 at 6.

52 *Supra*, note 24 and note 25.

53 Before the introduction of the first Good Samaritan statute in 1959, there were few reported cases involving actions taken against rescuers. Between 1970 and 1979, at least 15 cases were reported; and between 1980 and 1990, the figure rose to at least 26: 68 A.L.R. 4th at 294ff.

54 For example, it may be that Americans are becoming increasingly litigious at a greater rate than are Canadians. For a discussion of the "tort explosion" in the United States, see Fleming, *supra*, note 37 at 2.

It appears, however, that some segments of the Canadian population have experienced something of a "tort explosion" as well. For example, the number of actions filed against American physicians between 1979 and 1983 rose from 10,568 to 23,545, an increase of 123%: U.S. Dept. of Justice, *Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability* (Feb. 1986) at 45. During the same period, the number of writs filed against Canadian doctors rose from 343 to 700, an increase of 104%: F. Sellers, "The Potential Effect of Liability Claims on the Canadian Public Health Care System: A Need for Legal Reform and/or An Alternative to Litigation for the Compensation of Persons Disabled Because of Medical Misadventure" in *The Slater Report*, *supra*, note 47 at 363. Further, it has been suggested that while Canada is not yet "California North" in terms of tort law, some believe that it may become such: *The Slater Report*, *supra*, note 47 at 54; see also The Canadian Bar Association—Ontario, *Submission to the Minister of Financial Institutions in Response to the Ontario Task Force on Insurance* (1986) at 27.

honestly feel aggrieved, knowledge of the legislation may raise the possibility of filing an action. For individuals desirous of filing nuisance claims in the hope of extracting settlement money, the ambiguity with which Good Samaritan statutes have been drafted (as will be seen shortly) may provide fertile ground for litigation.[55]

III. AN ANALYSIS OF THE GOOD SAMARITAN STATUTES

While no two of Canada's Good Samaritan statutes are identical, all share some of the same provisions. It will be convenient to analyze the various acts by examining five elements that are common to most. The following chart identifies which of those elements are contained in each statute.[56]

Table of Good Samaritan Statutes

Jurisdiction	*Protected Classes*	*Limit On Situs*	*Assistance Must be Gratuitous*	*Assistance Must be Voluntary*	*Standard of Care*
Alberta[57]	A B* C* D*	Imm. Sc. Not Hosp.	No Yes	Yes	Gross Negligence
British Columbia[58]	A	Imm. Sc.	Yes	No	Gross Negligence
Saskatchewan[59]	A B** D*	Imm. Sc. Not Hosp.	No No	Yes	Gross Negligence
Newfoundland[60]	A B† D*	Imm. Sc. Imm. Sc.	No Yes	Yes	Gross Negligence
Nova Scotia[61]	E	None	Yes	Yes (?)	Gross Negligence

55 Most Good Samaritan statutes purport to immunize rescuers from liability, but not necessarily from litigation. The *Volunteer Services Act* of Nova Scotia is unique among Canadian statutes in providing that "no proceeding shall be commenced against a rescuer that is not based on his alleged gross negligence": *supra*, note 16 at ss. 2(2), 4. It is doubtful, however, that the Nova Scotia act offers any additional protection from vexatious lawsuits. Wherever legislation is in place, a plaintiff will likely claim for gross negligence. If not, his suit could be struck for failing to disclose a cause of action: e.g. *Alberta Rules of Court*, r. 129.

56 It will be recalled that Manitoba, New Brunswick, Ontario, and Quebec do not have Good Samaritan legislation.

57 *Emergency Medical Aid Act*, R.S.A. 1980, c. E-9.

58 *Good Samaritan Act*, R.S.B.C. 1979, c. 155.

59 *Emergency Medical Aid Act*, R.S.S. 1978, c. E-8.

60 *Emergency Medical Aid Act*, S.N. 1971, No. 15.

61 *Volunteer Services Act*, R.S.N.S. 1989, c. 497.

Jurisdiction	*Protected Classes*	*Limit On Situs*	*Assistance Must be Gratuitous*	*Assistance Must be Voluntary*	*Standard of Care*
Prince Edward Island[62]	F	Not Hosp.	Yes	Yes	Other (See Disc.)
Northwest Territories[63]	A D* G	None Not Hosp.	No No	Yes	Gross Negligence
Yukon[64]	A G‡	None Not Hosp.	No No	Yes	Gross Negligence

KEY

Protected Classes: A - Anyone not otherwise specified; B - Physician; C - Registered Health Discipline Member; D - Registered Nurse; E - Volunteer as defined by act; F - Member or associate member of the provincial College of Physicians & Surgeons, or physician or surgeon entitled to practice anywhere; G - Medical Practioner.

* Provincially or territorially registered

** Legally qualified medical practitioner within the meaning of the law of any province

† Lawfully entitled to practice in the province

‡ Registered, and entitled to practice, in any jurisdiction

Limit on Situs: Imm. Sc. - Assistance must be rendered at the immediate scene of accident or emergency; Not Hosp. - Assistance must not be rendered at a hospital or other place having adequate medical facilities.

A. Protected Classes

The classes of rescuers that enjoy protection as Good Samaritans vary considerably from jurisdiction to jurisdiction. Four provinces have no statutory protection.[65] Two provinces offer protection to all rescuers (subject to certain limitations to be discussed later).[66] Three other provinces and both territories offer protection to all rescuers (again, subject to certain limitations), while making special provisions for some members of the medical community.[67] One province has given special treatment only to physicians and surgeons.[68]

The effect of such diversity of protection may be at odds with the aim of Good Samaritan legislation. While little can be done to achieve a

62 *Medical Act*, R.S.P.E.I. 1988, c. M-5, s. 50.

63 *Emergency Medical Aid Act*, R.S.N.W.T. 1988, c. E-4.

64 *Emergency Medical Aid Act*, R.S.Y. 1986, c. 52.

65 Manitoba, New Brunswick, Ontario and Quebec.

66 British Columbia and Nova Scotia.

67 Alberta, Newfoundland, Saskatchewan, the Northwest Territories, and the Yukon.

68 Prince Edward Island.

uniform statutory scheme across the country, a patchwork of immunities may fail to assuage the fear that emergency intervention entails a risk of liability. Canadians enjoy constitutionally protected mobility rights[69] and the wide dissemination of information. A potential rescuer who has been exposed to conflicting advice concerning the prudence of providing assistance is unlikely to feel confident about intervening.

The scope of protection offered by several of the individual statutes also calls for comment. In Prince Edward Island, only physicians and surgeons are statutorily protected. It might be argued that such a limitation is justifiable because those individuals are particularly susceptible to the threat of legal action, and hence are in greater need of encouragement. As previously noted, however, it is not clear that Canadian doctors are generally inhibited from intervention by the fear of legal action.[70] Furthermore, while it is true that Good Samaritan laws of general applicability invite rescue from those who may lack proper medical training, it is also likely that in most cases, relief does not presuppose expertise. When a doctor is not present, a victim will usually be better served by assistance from a lay-person than by no assistance at all. Given the foregoing, one may wonder if the special status enjoyed by doctors in Prince Edward Island is not simply a product of the political power wielded by that group.

In five jurisdictions,[71] there are troublesome provisions pertaining to the availability of protection for some members of the medical community. Registration requirements applicable to certain individuals have the potential to produce unintended and unfair results. The *Emergency Medical Aid Act* of the Northwest Territories divided rescuers into two classes: (i) nurses who are territorially registered and medical practitioners, and (ii) other persons. Members of the first group benefit under the act only if the assistance they provide is not rendered at a hospital or other place having adequate medical facilities and equipment while the members of the second group are protected wherever they render their services. Conceivably, a nurse registered in another jurisdiction could provide emergency assistance while visiting a sick friend at a fully equipped hospital in the Northwest Territories. Since he would qualify

69 *Canadian Charter of Rights and Freedoms*, s. 6, Part I of the *Constitution Act*, 1982, being Schedule B of the *Canada Act*, 1982, (U.K.), 1982, c. 11.

70 *Supra*, at Section II(A)(B). There is little factual basis for such fear. As noted previously, a number of factors inherent in the litigation process insulate doctors from liability. And, while the law will raise its expectations when it is a doctor who has rendered medical services, the specific requirements imposed by the standard of care in each case are formulated in light of the "sudden peril" rule (*supra*, note 32); doctors are only required to live up to a standard which, in the circumstances, they ought to be capable of fulfilling.

Further, while it is true that the presence of malpractice insurance may attract litigation, it is also true that such insurance would alleviate the burden of any findings of liability.

71 Alberta, Saskatchewan, Newfoundland, Northwest Territories, and the Yukon.

as a member of the second class of rescuers, he would, unlike a local nurse involved in the same emergency, be able to claim the protection of the statute.[72]

It is suggested that all medical personnel, regardless of registration, should be expected to exhibit the same degree of competence when providing emergency assistance at a hospital or other place having adequate medical facilities. There does not appear to be any justification for granting preferential treatment to some rescuers merely because they are from another jurisdiction or are unregistered. It is also suggested that the appropriate standard of care is that which is employed under the common law.[73] It would not be unduly harsh to require physicians, nurses, and the like to conform their behaviour in a hospital setting to the model of the reasonably prudent person who has received similar training.[74] Such individuals ought to be familiar with the equipment and procedures that are available. In addition, a victim should not be forced to sacrifice his right to sue in negligence in order to receive a service to which he is already entitled.[75] In most hospital situations, a duty to rescue will be owed to the victim by someone close at hand.[76]

Peculiar results could also occur in the three provinces that employ the registration principle. Alberta, Saskatchewan, and Newfoundland use a classification scheme of rescuers similar to that used in the Northwest Territories.[77] In those provinces, however, members of the second (general) class of rescuers are only granted protection for services

---

72 A similar result is possible in the Yukon, where medical practitioners are only entitled to protection for services rendered in a hospital or other place having adequate medical facilities if they are registered, and entitled to practice, in any jurisdiction. Conceivably, aid could be rendered in a hospital by a person who is a qualified medical practitioner, but who is not registered or entitled to practice anywhere. That person would be entitled to Good Samaritan protection. A colleague who was registered and entitled to practice somewhere would not enjoy an immunity.

73 Admittedly, the issue is debatable. Some American statutes expressly grant Good Samaritan protection to members of the medical community who render assistance in a hospital setting: 68 A.L.R. 4th at 15-19.

74 While the standard is not lowered for novices, it is raised for specialists: A. Linden, *Canadian Tort Law*, 4th ed. (Toronto: Butterworths, 1988) at 142-50; Picard, *supra*, note 35 at 153-78, 293, 324. Of course, the standard of care may be tempered by the "sudden peril" doctrine in times of crisis: *supra*, note 32.

75 Discussed *infra*, Section III(D).

76 See e.g. A. Meagher, P. Marr & R. Meagher, *Doctors and Hospitals: Legal Duties*, (Toronto: Butterworths, 1991) at 4; Picard, *supra*, note 35 at 202.

77 In Alberta, the registration requirement applies to physicians, health discipline members, and nurses. In Newfoundland and Saskatchewan, the provision applies to nurses alone. Additionally, in Newfoundland, physicians receive protection only if they are entitled to practice medicine in the province; in Saskatchewan, physicians receive protection only if they are legally qualified as medical practitioners within the meaning of the law of any province.

rendered at the immediate scene of an accident or emergency.[78] Consider a situation in which a rescuer attempts to transport a victim to a hospital, but finds it necessary to provide first aid en route. The rescuer will be protected as a Good Samaritan if she is, for example, a provincially registered nurse, but not if she is a fully qualified nurse visiting from a neighbouring jurisdiction. Assuming that the primary aim of the legislation is to benefit victims, rather than to curry favour with the local medical community, the registration provisions seem inapposite.

B. Limit on Situs

The scope of immunity provided by all but one of Canada's Good Samaritan statutes is geographically limited.[79] The restrictions take two forms. Where medically trained individuals are treated as a separate class of rescuers, they are invariably denied protection for actions that are taken in a hospital or other place having adequate medical facilities and equipment.[80] As previously discussed, that limitation seems proper, though it is not applied broadly enough.[81] In British Columbia and Nova Scotia, where medically trained individuals are never recognized as a separate class of rescuers, the absence of such a limitation could produce questionable results. The *Good Samaritan Act* of British Columbia extends an immunity to everyone other than those who are expressly employed to provide emergency assistance or who act with "a view to gain".[82] The *Volunteer Services Act* of Nova Scotia grants protection to all "volunteers." A "volunteer" is defined as one who is "not in receipt of fees, wages or salary for the services or assistance" rendered, "whether or not that individual has special training".[83] As suggested by a number of American decisions, it appears that it might be possible for a physician temporarily occupying an administrative position in a hospital, for example, to claim the protection of the *Good Samaritan Act* or the

78 Those to whom the registration requirement applies are again protected only for services that are not rendered at a hospital or other place having adequate medical facilities and equipment.

Difficulties concerning the issue of the "immediate scene of the accident or emergency" provision will be examined shortly.

79 The *Volunteer Services Act* of Nova Scotia does not contain a restriction on the situs of emergency care.

80 Such a limitation is found in the legislation of Alberta, Saskatchewan, Newfoundland, the Northwest Territories, and the Yukon. The *Medical Act* of Prince Edward Island uses a slightly more restrictive limitation. A reduced standard of care applies only to services provided "outside of a hospital or doctor's office, or any other place not having proper and necessary medical facilities."

81 As argued above, the limitation should apply to all medically trained rescuers, not just those who fall into certain classes based on registration.

82 *Supra*, note 58 at s. 2.

83 *Supra*, note 61 at s. 2(1).

Volunteer Services Act if he attempted to provide assistance during an emergency in the hospital.[84] It is possible, though doubtful, that the British Columbia and Nova Scotia legislatures intended to use the promise of immunity to encourage intervention from everyone not specifically employed to undertake rescues.[85] In such circumstances, the statutes would often work to the detriment of the primary intended beneficiary of the legislation, the victim. It would deprive him of his right to bring an action for negligence while only marginally improving his chances of being rescued.[86]

A second type of geographical restriction is used by the four provinces whose acts provide immunity only to those who supply assistance at "the immediate scene of the accident or emergency" which has caused the illness, injury or unconsciousness of the victim.[87] Legislators in at least two jurisdictions wisely recognized that undesirable results could flow from that limitation, and expressly chose not to include it in their legislation.[88] The restriction would, for example, deny protection to a rescuer who provided aid to a victim who had wandered in a daze after being injured. Similarly, it would deny the benefit of a reduced standard of care to one who ministered to a victim while en route to a hospital.[89]

C. Assistance Must be Gratuitous

In Alberta, Newfoundland, and Prince Edward Island, certain medically trained rescuers must act "without expectation of compensation or

---

84 It would be otherwise if the physician's contract of employment contemplated such actions notwithstanding the fact that he was serving as an administrator. The American cases on point are discussed in 68 A.L.R. 4th at 323-8.

85 On at least two occasions, American courts dealing with similar provisions have held that such a result could not have been intended by a legislature, and have therefore denied the availability of Good Samaritan protection: *cf. Clayton* v. *Kelly* 183 Ga. App. 45, 357 S.E. 2d 865 (1987); *Henry* v. *Barfield* 186 Ga. App. 423, 367 S.E. 2d 289 (1988). It is possible, though not certain, that a Canadian court would take a similarly restrictive approach to the interpretation of the *Good Samaritan Act* and the *Volunteer Services Act.*

86 On the facts of the hypothetical, help might have come from a physician expressly employed to render emergency assistance if the physician filling the administrative position had not done so first: *supra,* note 76.

87 In Alberta, Saskatchewan, and Newfoundland, the restriction applies to rescuers who are not specially recognized medical professionals. In British Columbia the restriction applies to all rescuers.

88 See *Council of the Northwest Territories Debates,* 13 February 1976 at 890; *Debates and Proceedings of the Yukon Legislative Assembly, supra,* note 5 at 34.

89 It might be argued that "the immediate scene of the accident or emergency" that has imperilled a victim follows her about until she has received adequate relief. It is suggested, however, that such an interpretation untenably strains the natural meaning of the words of the legislation, and therefore ought to be rejected.

reward" if they wish to gain protection as Good Samaritans.[90] In British Columbia, any person who is expressly employed for the purpose of rendering aid, or who acts "with a view to gain", will invariably be held to the common law standard of care.[91] And in Nova Scotia, only those who are "not in receipt of fees, wages or salary for the services or assistance" provided come within the scope of the *Volunteer Services Act*.[92] It is questionable whether there is any merit in requiring rescuers to forego monetary compensation in order to benefit under a Good Samaritan statute.

Two preliminary comments will help to limit the scope of the discussion that follows. First, one who receives compensation for the provision of emergency services will often have acted pursuant to a duty. The effect that a pre-existing obligation has on the applicability of a Good Samaritan statute will be discussed in the next section. Second, unless expressly employed for the purpose of rendering aid, few rescuers will have a legal right to insist upon payment. The law only clearly recognizes the validity of a restitutionary claim when it is pursued by a physician.[93] Furthermore, a contractual claim brought on the basis of a promise made during an emergency will fail on the grounds of unconscionability, inequality of bargaining power, or duress,[94] and a promise made by a victim subsequent to a rescue will be unsupported by good consideration, and hence unenforceable.[95]

Although of questionable merit, the requirement of gratuitousness is not totally indefensible. As Landes and Posner have pointed out,[96] a doctor who renders emergency services is entitled under common law principles to claim restitutionary relief in an amount equal to his usual

---

90 In Alberta, the requirement applies to physicians, registered health discipline members, and registered nurses; in Newfoundland, it applies to physicians and registered nurses; and in Prince Edward Island, it applies to physicians and surgeons.

91 *Supra*, note 58 at s. 2.

92 *Supra*, note 61 at s. 2.

93 *Cf. Matheson* v. *Smiley* [1932] 2 D.L.R. 787, [1932] 1 W.W.R. 758 (Man. C.A.); *Cotnam* v. *Wisdom* 104 S.W. 164 (Ark. S.C., 1907); P. Maddaugh & J. McCamus, *The Law of Restitution* (Aurora, Ont.: Canada Law Book, 1990) at 693; Lord Goff & G. Jones, *The Law of Restitution*, 3rd ed. (London: Sweet & Maxwell, 1986) at 342-3; *cf.* G. Palmer, *The Law of Restitution* (Boston: Little, Brown, 1978) at 104.

94 E.g. *Post* v. *Jones* 60 U.S. (19 How.) 150 (U.S.S.C., 1857).

95 Services that precede a promise are considered past consideration, and past consideration is generally considered to be no consideration at all: e.g. *Eastwood* v. *Kenyon* (1840) 11 Ad. & El. 438; *Re Grosch* [1945] 3 D.L.R. 63. In the United States, an exception to the consideration rule is recognized in emergency circumstances: see *Webb* v. *McGowin* 27 Ala. App. 82, 168 So. 196 (1935).

96 W. Landes & R. Posner, "Salvors, Finders, Good Samaritans and Other Rescuers: An Economic Study of Law and Altruism" (1978) 7 J. of Leg. Stud. 83, at 127.

fee.[97] Since the composition of that fee contains an allotment towards his malpractice insurance premium,[98] he will have little actual need for protection from liability if he charges for his services. Any damages awarded against him will be borne by the insurance for which the victim has paid. Of course, as previously discussed, the true value of Good Samaritan legislation may lie in its capacity to facilitate rescue by assuaging fears caused by the perception of a danger. Such fears may exist notwithstanding the absence of an actual danger.

In the past, the gratuitousness requirement might have been defensible on the ground that a victim should not have to pay twice for rescue, once monetarily, and again by giving up the right to sue in negligence. Today, however, that argument is extremely attenuated, for it is very unlikely that a victim will personally pay for a doctor's services.[99] Health care insurance schemes have been established in every province in which a gratuitousness provision is operable.[100] Pursuant to those schemes, a person becomes entitled to "free" medical services upon payment of a premium; doctors who participate in the plans collect remuneration for their work from a provincial commission rather than from individual patients.[101] Given that the ultimate aim of the Good Samaritan legisla-

---

97 That principle is recognized in Canada, as well as in the United States: *supra*, note 93.

98 The same holds true of doctors who receive compensation through provincial or territorial health insurance schemes: discussed *infra*, at note 100.

99 It is for that reason that the *Emergency Medical Aid Act* of the Northwest Territories does not require that assistance be gratuitously provided: *Council of the Northwest Territories Debates*, *supra*, note 88 at 890.

100 *Alberta Health Care Insurance Act*, R.S.A. 1980, c. A-24; *Medical Service Act*, R.S.B.C. 1979, c. 255; *Newfoundland Medical Care Insurance Act*, R.S.N. 1970, c. 265; *Health Services and Insurance Act*, R.S.N.S. 1989, c. 197; *Health Services Payment Act*, R.S.P.E.I. 1988, c. H-2.
The discussion of the acts that follows, while admittedly simplified, is sufficient for present purposes.

101 It is possible for a doctor to "opt out" of his province's scheme, and to generally bill his patients directly for care that he provides. Complications will arise, however, if he renders services in an emergency. The situation in each of the five provinces under consideration is different.
In Alberta, a physician or dental surgeon who renders emergency services is entitled to benefits under the plan even if he has opted out. Alternatively, he may bill the person to whom he has provided assistance, who may then claim reimbursement from the provincial plan: *Alberta Health Care Insurance Act*, *ibid.* at s. 5.2(6). In Newfoundland, physicians do not have the option of claiming under the provincial plan for emergency services they have provided, though they are entitled to bill the patient, who can then claim reimbursement: *Newfoundland Medical Care Insurance Act*, *ibid.* at s. 26(3). A very similar situation occurs in Prince Edward Island: *Health Services Payment Act*, *ibid.* at s. 10. In Nova Scotia, a physician who has opted out is not entitled to charge for his services unless, prior to rendering them, he gives reasonable notice of the fact that he is not a participant in the provincial plan. In the unlikely event that this requirement is met in an emergency situation, the recipient of the services would be able to claim reimbursement for the amount he paid: *Health Services and Insurance Act*, *ibid.* at s. 28(1)(2). It is only in British Columbia that an individual would likely have to personally pay for assistance that he receives. A practitioner who has opted out of that province's plan is free to charge for his services, but a patient who has paid such a fee is only

tion is to benefit victims, rather than to increase the incidence of charitable behaviour *per se*, the effect of the gratuitousness requirement would appear negative. While victims will be indifferent to the matter of compensation because of the provincial health care insurance schemes, doctors may not be eager to intervene in an emergency if it entails either a (perceived) risk of liability, or foregoing remuneration.

While a doctor in certain jurisdictions[102] will be prevented by the gratuitousness requirement from simultaneously claiming compensation and Good Samaritan protection (subject to an exception to be discussed next), it is possible for him to avoid unnecessarily sacrificing the former. Prior to seeking remuneration for his services, he could simply wait and see if an action was filed against him.[103] If so, he could forego his fee in favour of a reduced standard of care if he felt that such a course of action was ultimately in his best interests.[104]

In British Columbia, some[105] doctors may be able to pursue part of their restitutionary claims and still qualify for a reduced standard of care.[106] The *Good Samaritan Act* of that province simply requires that a rescuer not render aid pursuant to the express terms of any employment, or "with a view to gain."[107] While an action to recover remuneration for services rendered would probably violate that requirement, it does not appear that an action to recover reimbursement for expenses incurred would have the same effect. A claim of the latter variety would simply

---

entitled to reimbursement from the plan if, prior to rendering any services, the practitioner provided written notice of his status: B.C. Reg. 144/68, Reg. 5.10. It is hard to imagine such a sequence of events ever occurring in an emergency.

102 Alberta, British Columbia, Newfoundland, Nova Scotia, and Prince Edward Island.

103 A physician who had opted out of his provincial health care insurance plan would have to seek compensation under common law principles, except in Alberta: *supra*, note 101. Under those principles, restitutionary relief is only available if a physician had an intention to charge for his services when he rendered them: *Matheson* v. *Smiley*, *supra*, note 93. However, such an intention will be readily presumed (see e.g. Maddaugh & McCamus, *supra*, note 93 at 693; Goff & Jones, *supra*, note 93 at 343; *Restatement of the Law of Restitution* (St. Paul: American Law Institute, 1937) at 116 comment a) and in any event, need not be communicated immediately. Admittedly, there may be an ethical dilemma if a doctor wishes to receive compensation, but had originally intended to provide free aid.

104 The decision might not be as obvious as it seems. Given the difficulties invariably faced by those who sue physicians (*supra*, Section II(A)), and the fact that any damages to be paid would be borne by an insurer, the prudent choice might be to forego the Good Samaritan immunity and to pursue restitutionary relief. On the other hand, a physician may opt for the additional protection of the Good Samaritan legislation if he fears that an adverse verdict would generate unfavourable publicity, or would dramatically increase his insurance premiums.

105 The argument could only be made by a physician who had opted out of the provincial health care insurance plan. A physician who participated in the plan would be precluded from pursuing any claims against a victim by the *Medical Service Act*: *supra*, note 100.

106 Elsewhere, the argument would be foreclosed by the provisions of the Good Samaritan statutes, and by the legislation pertaining to provincial health care insurance schemes.

107 *Supra*, note 58 at s. 2.

restore a doctor to the position he was in prior to providing assistance; it would not allow him to gain from intervention.[108]

D. Assistance Must be Voluntary

Six of Canada's Good Samaritan statutes protect only those who "voluntarily" provide assistance.[109] Despite some curious evidence to the contrary,[110] it is suggested that this term ought to be interpreted so as to deny protection to intervenors who act pursuant to a "duty to rescue."[111] One who acts under an obligation does not act voluntarily. Furthermore, when a legal obligation to provide assistance is incapable of eliciting action, it seems unlikely that a promise of immunity will produce a response.[112] To the extent that this is true, a victim's right to recover damages for a failure to adequately undertake a rescue should not be unnecessarily diminished by the availability of Good Samaritan protection.[113]

Neither the *Volunteer Services Act* of Nova Scotia nor the *Good Samaritan Act* of British Columbia contains a requirement of voluntari-

---

108 It would also be theoretically possible for a doctor to claim remuneration in an amount that would not include a profit component. Such a claim would, however, be most difficult to accurately quantify.

109 Alberta, Saskatchewan, Newfoundland, Prince Edward Island, the Northwest Territories, and the Yukon.

110 While somewhat ambiguous, there was a suggestion in the Yukon Legislative Assembly that "voluntarily means willingly" in the sense of an intentional, conscious act: *Debates and Proceedings of the Yukon Legislative Assembly, supra,* note 5 at 31. Because it is difficult to imagine a rescuer unwittingly providing assistance, that definition of "voluntarily" ought to be rejected.

111 When construing statutes similar to those found in Canada, American courts have consistently held that the presence of a pre-existing duty precludes the application of Good Samaritan legislation: see 68 A.L.R. 4th at 317ff.

For a discussion of the situations in which a person will be subject to a duty to rescue, see McInnes, *supra,* note 2.

112 In exceptional circumstances, it could be otherwise. One might be more apt to remain anonymous, and thus avoid prosecution, by simply passing by an emergency. A person may want to fulfil his obligation to render assistance but may fear that he will reveal his identity to someone who may sue him if he does so. In such circumstances, Good Samaritan protection may have an effect that a duty to rescue would not.

It should also be noted that assistance becomes more likely as the cumulative effect of the various forces urging intervention mount. For a discussion of the psychological processes leading to intervention see M. McInnes, "Psychological Perspectives on Rescue: The Behavioral Implications of Using the Law to Increase the Incidence of Emergency Intervention" (1992) 20 Man. L.J. 657.

113 Again, it is assumed that the primary aim of the legislation is to benefit victims by increasing the likelihood of rescue. Some have suggested that Good Samaritan statutes are also aimed at simply expressing gratitude to those who provide assistance: e.g. J. Norris, "Current Status and Utility of Emergency Medical Care Liability Law" (1980) 15 The Forum 377 at 387. It is questionable, however, whether a victim's common law right to either rescue or damages ought to be sacrificed for such a reason.

ness of the type that has been recommended. The former act defines a "volunteer" as one who is not "in receipt of fees, wages or salary for the services or assistance" rendered,[114] while the latter denies its protection to those who are expressly employed to provide emergency care or who act "with a view to gain".[115] A strained interpretation of the latter phrase could encompass those who render aid in order to avoid being held liable for failing to fulfil an obligation to perform a rescue. More realistically, however, it must be concluded that rescuers in British Columbia, as well as those in Nova Scotia, may come within the scope of their provinces' Good Samaritan legislation even if they were obliged to provide assistance.

E. Standard of Care

Generally, Good Samaritan statutes reduce a rescuer's standard of care such that liability will lie only for gross negligence. In other areas, the courts have had difficulty defining the type of conduct that will run afoul of that standard,[116] and some have suggested that its use will, paradoxically, serve to encourage litigation in the present context.[117] In any event, given that ordinary negligence in emergency situations is judged in light of the "sudden peril" doctrine, it is clear that all but the most outrageous conduct will be excused when the legislation applies.[118]

The *Medical Act* of Prince Edward Island protects only physicians and surgeons. When applicable, it reduces a defendant's standard of care such that liability will lie only if harm is suffered as a result of conduct which, "if committed by a person of ordinary experience, learning and

---

114 *Supra*, note 61 at s. 2(1). The definition of "volunteer" that is found in the Nova Scotia statute can not be applied to the term "voluntarily" as it is found in four of the Good Samaritan statutes. In one province (Prince Edward Island), the requirement of voluntariness applies alongside a requirement that services not be rendered in the expectation of compensation. In three other provinces (Alberta, Saskatchewan, and Newfoundland), the requirement of voluntariness applies to individuals who must render their services without expectation of compensation and to those to whom no such limitation applies. In all four jurisdictions, the term "voluntarily" would be redundant if interpreted as being synonymous with "volunteer" as it is found in the Nova Scotia legislation.

115 *Supra*, note 58 at s. 2.

116 For a discussion, see Klar, *supra*, note 29 at 228-30.

117 See Gray & Sharpe, *supra*, note 40 at 6.

118 An example of the type of conduct that has attracted liability is seen in the American case of *Ballou* v. *Sigma Nu General Fraternity* 291 S.C. 140, 352 S.E. 2d 488 (App., 1986). Members of the defendant fraternity induced the plaintiff to consume excessive amounts of alcohol. When they realized that they had imperilled the plaintiff, they attempted to provide emergency assistance, but did not proceed to a hospital. The court held that Good Samaritan protection was not available as the actions constituted gross negligence.

skill, would constitute negligence."[119] The act, it is suggested, goes too far in its attempt to encourage doctors to provide aid. There can be no valid justification for allowing a doctor to completely ignore the fact that she has had years of training and practical experience.[120] Any positive responses elicited by the standard of care found in Prince Edward Island could probably also be achieved by applying the more commonly used gross negligence standard to physicians and surgeons.[121]

IV. SUMMARY AND CONCLUSION

Though an increased incidence of emergency intervention is certainly a goal worthy of promotion, it is questionable whether Canada's Good Samaritan statutes are an appropriate means for achieving that end. While the common law may be perceived by some to be threatening, in practice rescuers have little reason to fear it. Both the common law rules pertaining to emergencies and the realities of the litigation process significantly limit a victim's ability to recover damages for mishandled efforts. Therefore, if possible, it would be better simply to educate potential rescuers to the fact that intervention actually entails a negligible risk of liability. Absent an educative mechanism, however, it may properly fall to the law to assuage fears and to encourage succour by reducing the standard of care applicable to intervenors. Such a step should only be taken if it can be shown that it will have a positive effect; as yet, it is not clear that Good Samaritan statutes lead to more rescues.

If Good Samaritan legislation is to be used in an attempt to promote rescue, it should be drafted carefully so that it will achieve its objective with a minimum of undesirable side effects. On the basis of the foregoing discussion, the following recommendations are made:

(i) protection should generally be extended to all potential rescuers;

(ii) protection should not be denied only because assistance is not rendered at the immediate scene of an accident or emergency;

(iii) protection should be denied to all members of the medical community for services that are rendered at a hospital or other place having adequate medical facilities and equipment;

(iv) protection should not be denied only because one does not act gratuitously;

---

119 *Supra*, note 62.

120 At common law, a doctor is expected to act as a reasonably prudent practitioner would act in like circumstances. Though the standard is not lowered for novices, it is raised for specialists: *supra*, note 74.

121 *Supra*, note 76.

(v) protection should be denied to one who has an obligation to provide assistance; and

(vi) when applicable, Good Samaritan legislation should reduce a rescuer's standard of care such that liability will lie only for injuries that are caused by gross negligence.

The implementation of these recommendations would result in a statute more apt to induce rescue, and less apt to engender confusion and injustice.