The Physician as Ambivalent Samaritan

Will Internists Resuscitate Victims of Out-of-Hospital Emergencies?

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To determine how internists would respond to out-of-hospital emergency medical situations, we surveyed internal medicine residents and attending physicians at urban academic medical centers regarding their willingness to help in five such scenarios. For those scenarios in which they were reluctant to help, they were asked why. Knowledge of Good Samaritan statutes was also assessed. Respondents were most likely to give aid, including mouth-to-mouth resuscitation if necessary, in scenarios involving a man complaining of chest pain in a restaurant (69%) and a call for help on an airplane (54%), and least likely to help a disheveled man lying on the sidewalk (2%). The most common reasons for not helping were a reluctance to perform mouth-to-mouth resuscitation, feeling that it was not one's responsibility to help, and concern about infectious disease. Knowledge of New York's Good Samaritan law was not associated with willingness to help.

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In the Good Samaritan parable (Luke 10.30–37), a man is attacked by robbers and left for dead on the road from Jerusalem to Jericho. A priest and a Levite pass him by, but a Samaritan man stops, binds his wounds, and cares for him.

Although the scenario of coming upon someone in such desperate circumstances in a public place is sadly common in today's society, the willingness of physicians to act as Good Samaritans and assist in out-of-hospital emergencies, providing cardiopulmonary resuscitation (CPR) when needed, is less certain. A medical emergency outside the hospital or medical practice setting can be one of the most unnerving situations a physician encounters. Ample evidence exists that CPR performed early in the field greatly increases the victim's chance of survival.[1] Although most physicians feel an obligation to assist in such scenarios, this desire is often tempered by conflicting feelings[2] (also see Kramer P. A rescue without cheers. New York Times Magazine. July 16, 1995:15). Some physicians have expressed a lack of comfort with their emergency CPR and trauma skills, fear of contagious disease, and concerns about legal repercussions.[1]

All 50 states have enacted legislation protecting health care professionals who act as Good Samaritans, and New York's law is typical.[3] It states that a physician who acts as a Good Samaritan can be proved negligent only if he or she purposefully and with malicious intent causes harm to the victim. Despite these laws, studies suggest that many physicians choose not to get involved.[4] In a 1963 survey asking physicians whether they would stop to help at a roadside accident, half said that they would not, and that a Good Samaritan statute would not make a difference.[5,6]

In this study, we sought to answer the following two questions: (1) How willing are internists to perform CPR in specific out-of-hospital emergency medical situations? and (2) What are the barriers to providing assistance?

METHODS

We distributed a self-administered, anonymous survey to a convenience sample of general internal medicine attending physicians and housestaff at two urban academic medical centers in New York City. The survey included five common out-of-hospital emergency scenarios (Table 1). The physicians were asked to indicate their willingness to help in each scenario on a 5-point scale with answers ranging from 1 for "definitely would help" to 5 for "definitely would not help." The instructions stated that choosing 1 indicated a willingness to give mouth-to-mouth resuscitation if necessary ("definite helpers"). If subjects chose anything other than 1, they were instructed to select the reasons why they were unwilling to help from a list following each question or to write in another reason. The scenarios and the reasons for not helping were based on information from a focus group with colleagues and a pilot survey. The order of the scenarios was the same on each questionnaire: subway, restaurant, sidewalk, highway, airplane.

The questionnaire also assessed knowledge of Good Samaritan laws. The first question asked whether New York state has such a law. The second question addressed the content of Good Samaritan laws in states that have them. From a multiple choice list, respondents were asked to identify such laws' usual contents.

We summarized the proportion of responses for each scenario as a histogram. Responses were dichotomized as "definite helpers" versus all others to further distinguish the definite helpers' willingness to provide mouth-to-mouth resuscitation. We used χ^2 tests to compare the

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Table 1. Willingness to Resuscitate Victims of Out-of-Hospital Emergencies

Scenario	Definite Helpers*, % (95% CI)
Sidewalk: While walking to work on a cold winter morning, with the wind-chill estimated to be 0 degrees Fahrenheit, you almost trip over a disheveled man with a bushy beard, filthy sweatshirt, and an empty bottle of wine lying on the sidewalk.	2 (0, 6)
Subway: While sitting in a subway car, you notice a disheveled cachectic woman who is making her way down the car and suddenly collapses. She appears not to be breathing.	33 (20, 46)
Highway: While driving on a highway, you see a car collide into a divider. As you slow down, you can see a shattered windshield. No one else has arrived at the scene.	44 (31, 57)
Airplane: While just falling asleep on a transcontinental flight, you hear an announcement asking if there is a physician on the plane.	54 (41, 67)
Restaurant: While dining in a restaurant, you see a man across the room clutching his chest. He appears to be light-headed, diaphoretic, and anxious. A waiter indicates that an ambulance is on the way.	69 (57, 81)

* *"Definite helpers" indicated those willing to provide mouth-to-mouth resuscitation, if necessary.*

proportion of definite helpers for the following subgroups: men versus women, residents versus attending physicians, and those who correctly identified New York state's Good Samaritan law versus those who did not.

RESULTS

Of 54 physicians, 52 (96%) responded to the survey. The mean age of the 37 residents was 29, and 52% were female. The mean age of the 15 attending physicians was 33, and 40% were female. Figure 1 illustrates the range of responses to each scenario, in increasing order of willingness to "definitely help." A majority of the respondents indicated that they would be definite helpers in the restaurant and airplane scenarios (69% and 54%, respectively) (Table 1). Forty-four percent indicated that they would be definite helpers at the highway accident, as would 33% on the subway. Only 1 person (2%) would definitely help the man lying on the sidewalk.

Analysis of each scenario by level of training revealed a statistically significant difference only in the highway

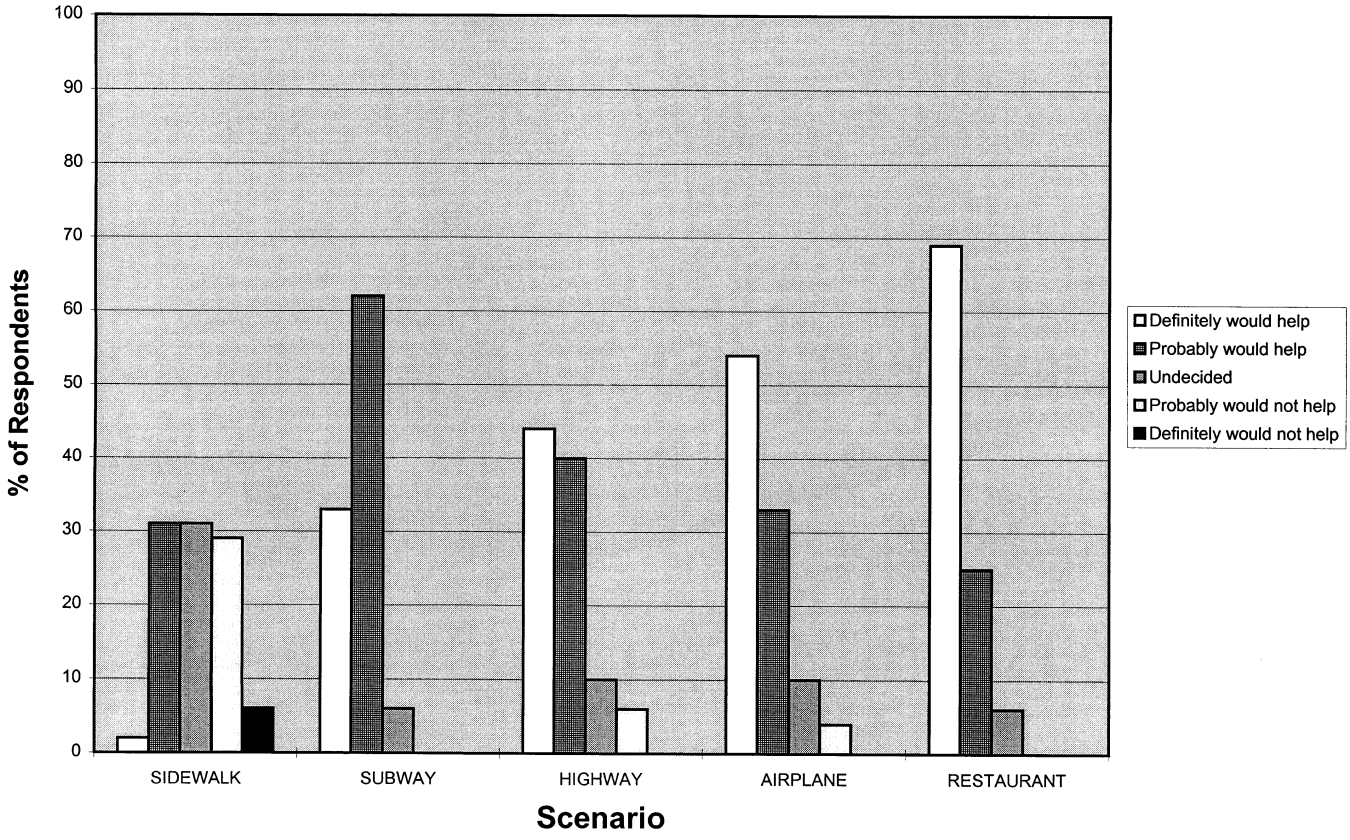

FIGURE 1. Responses to each scenario.

situation. Attending physicians were less likely than residents to definitely help at the roadside accident (13% vs 57%, $p = .01$). Analysis of each scenario by gender did not reveal significant differences in willingness to help.

The most common reason cited for not helping was a reluctance to perform mouth-to-mouth resuscitation, which 63% chose for at least one scenario. Fifty-two percent indicated that it was not their responsibility to help. Thirty-six percent were concerned about contracting infectious disease, 29% had a lack of comfort with their acute medical care skills, and 17% feared legal repercussions. Only the sidewalk scenario was significantly associated with a specific reason for not helping. Compared with the other scenarios, respondents were more likely to indicate that they did not feel it was their responsibility to help the man lying on the sidewalk.

The existence of a Good Samaritan statute in New York state was recognized by all the attending physicians and by 89% of the residents. However, only 15% of the respondents correctly identified the contents of Good Samaritan laws in general. There was no difference between residents' and attending physicians' knowledge of the laws' usual contents. Physicians aware of New York's law were not significantly more likely to be definite helpers than those who were not aware of the law.

DISCUSSION

Despite the fact that CPR is known to save lives, the majority of the respondents to our survey indicated that they would not perform CPR in a variety of out-of-hospital settings. The most common reasons cited involved concerns for personal risk.

The situations with the lowest response rates were the subway and sidewalk scenarios, in which the victims may have appeared more likely to have a communicable disease. Medical history is replete with tales of physicians contracting dreaded diseases in the line of duty. Other physicians, seeking to avoid risk, have fled approaching epidemics with no regard for their patients' health. Even Galen quickly left Rome when the Antonine plague struck in 165 A.D.[7]

The airplane and restaurant scenarios had the highest response rates. This may be due to the perception that people in a higher socioeconomic class pose less of a communicable disease risk to their potential resuscitators. Class empathy may have also played a role in these responses. In addition, respondents may have assumed that the man's condition in the sidewalk scenario was due to alcohol and therefore self-inflicted. The acuity and seriousness of the illness were intentionally ambiguous in some of the scenarios. Respondents may have assumed that the disheveled man on the sidewalk was not particularly sick; others may have assumed that their CPR skills were inadequate and that their presence would be unhelpful.

The second most common reason for not definitely helping was a feeling that it was not one's responsibility to help. Some physicians might reply to this by saying, "If not us, then whom?" Physicians have more training in emergency care than lay people, but does this knowledge impart an obligation to provide care whenever an emergency is encountered? Even the Hippocratic Oath is ambiguous on this issue: "into whatever houses I enter, I will go into them for the benefits of the sick . . ." The physician's responsibility is less clear when the sick lie outside the "house."

In the roadside scenario, with a clear implication of trauma, attending physicians were less likely to help than residents. This may be due to the fact that residents are steeped in the inpatient environment and more accustomed to dealing with emergencies. Residents are also more likely than attending physicians to have up-to-date Basic Life Support and Advanced Cardiac Life Support training, suggesting that comfort with acute medical care skills may affect the decision to help.[2,4]

Our study also showed that most internists could not correctly identify the contents of their state's Good Samaritan law. We had postulated that a risk of legal repercussions would be a commonly cited reason for not getting involved in emergency situations. However, respondents' answers did not appear to be affected by a fear of legal liability. There was no significant difference between those who knew the contents of Good Samaritan laws and those who did not, and only a small number cited legal concerns as a reason not to help. Interestingly, there have been only a few reported cases in the United States or Canada of a physician being sued for malpractice secondary to treatment given during an out-of-hospital medical emergency.[4,8]

This study is limited by its modest sample selected from two urban academic medical centers. The respondents were drawn from a convenience sample of housestaff and relatively young attending physicians in general internal medicine divisions in New York City. This sampling methodology was used to obtain a high response rate and limit expenditures; however, the experiences and attitudes expressed by these physicians may not be representative of a more systematic sample. Responses to hypothetical vignettes may not accurately represent physicians' true behavior. If anything, respondents may have overestimated their willingness to resuscitate. The scenarios did not specify whether the protagonists were busy or at leisure, alone or in a group. The checklist of reasons for not helping may have constrained the range of responses. In addition, respondents may have been biased by the order of presentation by considering each vignette in comparison with the previous ones.

The results of this study, although preliminary, are sobering. When faced with a moment of truth in an out-of-hospital emergency, we must each decide for ourselves. Many physicians may not be willing to provide mouth-to-mouth resuscitation in out-of-hospital emergencies. Future studies should examine the impact of prior Good Samaritan experiences, availability of masks and gloves,

certification status for Advance Cardiac Life Support and Basic Life Support, cultural expectations, and prior litigious experiences on willingness of physicians to help.

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