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Citizen Samaritans and Public Perils: Our Duties to Doctors

While physicians have a duty to treat even at the risk of their own personal safety, citizens also have minimal obligations to assist those protecting them during bioterrorism or natural disasters.

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A cruise ship strikes an iceberg in the middle of the night, and the ship starts taking on water at an alarming rate. This vessel wasn't like the ships of yesteryear. It was even believed to be unsinkable…until now. While the crew has been trained to serve and care for the passengers generally, nothing like this was anticipated. Suddenly we face the potential for mass scale disaster where only moments ago such a catastrophe would have been thought as consigned to the misadventures of historical record, eradicated by the steady march of science and technology.

Instructive similarities can be drawn from this analogy to the case of disease contagion that we face today. Concerns have resurfaced from the optimism of the 1950s when it was believed that penicillin and other medical advances had rendered problems of pestilence, plague, and widespread contagion a thing of the past. But that was before HIV, West Nile, bioterrorism, SARS, monkeypox, and now, fears of a reprise of the 1918-1919 pandemic with a new avian flu vector.

There are strong arguments to show that physicians have a duty to treat during such social emergencies, even at personal risk [1]. The view is supported by the history and meaning of the AMA's *Code of Medical Ethics* as well as by exposing the moral soundness of its assumptions. Key elements in the argument are, first, the existence of an implicit social contract exchanging service-in-trust for professional autonomy and its attendant benefits. Second, Norman Daniels' argument identifies consent-based obligations that physicians assume by freely joining the profession designed to combat disease. And third, a promissory quality of the consent-based obligation follows from taking a public oath.

But if physicians are to put themselves at risk for citizens, do citizens have obligations to assist their physician benefactors in return? I have already mentioned compensation to the medical profession in terms of the financial, professional, and social benefits bartered in the social covenant. But are there other obligations citizens might owe medical professionals in times of public need?

In approaching the question, we might reason toward more sound conclusions by the use of analogies. Consider for instance, a swimmer in trouble. While everyone who is able to help has some obligation to assist a swimmer in need (throw a float, a line, call for help), it seems clear that a lifeguard has greater moral obligations to assist by virtue of superior skills and by freely having joined the ranks of professional lifeguards. Indeed, specialized training enables the lifeguard to assist more effectively and in ways that actually serve to secure greater safety for the lifeguard than for the average bather on the beach.

The skills of the lifeguard are instructively similar to medical and professional skills in times of public peril. But what about the unskilled bathers on the beach? Do they have duties to the lifeguards? And what about situations where many people are suddenly in imminent danger rather than cases of a swimmer or 2 having ventured too far from shore.

Rethinking the Titanic analogy above (in case you haven't guessed!) helps us frame this larger question. But first, let us draw some needed distinctions concerning duty to render aid.

Judy Jarvis Thomson's treatment of the concept of Samaritanship can motivate a basis to think that we all have obligations to render assistance [2]. Thomson draws distinctions between splendid, good, and minimally decent Samaritanship. Using the example of the Kitty Genovese case, where 38 watched and did nothing as Kitty Genovese was brutally murdered—not even a phone call to police—Thomson notes that this failure to act falls below minimal decency, a standard we should never fall below. The Kitty Genovese case yields 4 prominent factors that together generate and shape our duty to assist: (1) a critical need, (2) proximity of a person to the need, (3) capability of the person to act, and (4) the absence of other adequate and available assistance at the scene [3].

In view of these 4 points, let us consider 2 cases: minimal citizen Samaritans (MCS), and good citizen Samaritans (GCS). In the minimal case there are 2 further divisions: (1) disaster duties, and (2) predisaster duties (to prepare). In the first case (MCS-1), perhaps a moral minimum for the passengers on the sinking ship is for persons to cooperate with the instructions of the crew, and thus for citizens to cooperate with physicians at the scene during public peril. This is all the more important since it is clearly in the interests of the passengers themselves—or citizens—to avoid panic. Further, just as allowing the crew first access to the life jackets enables them to do their work more effectively, citizens should grant health care workers first access to necessary protections and inoculations.

As to the second class of minimal obligations (MCS-2), predisaster preparation should include something like a surcharge on the voyage ticket to pay for special training of the crew. This would translate into funding for the requisite special training for health care workers and funds to benefit the families of those workers who might fall in the line of duty. It should also include some prevoyage drills for passengers to perform regarding where and how emergency supplies, services, and evacuation procedures might be utilized and located. This translates into training drills, similar to fire drills, etc, designed for bioterror attack or an outbreak of naturally occurring pestilence.

Beyond the minimal level, we might even consider some measures for the few who feel a higher call to assist: the good citizen Samaritans (GCS). These are the passengers who are stalwart and able bodied who wish to take special courses in first aid and life-saving methods. As such, these good Samaritans might register with the crew before the voyage to be potential deputized assistants. A similar sort of deputized training might be made available for certifying and deputizing good citizen Samaritans as bioterror and pestilence assistants.

In sum, citizens need to have a sense of their minimal obligations to assist those who work to protect them in times of bioterror or natural pestilence. At this minimal level, our duty to physicians is rather light. Minimally, we need to be ready to fund preparations properly, cooperate during perils, do some practice preparations, provide adequate compensations (ie, to family and spouses), and optionally, but not manditorily, assist front line workers as trained deputies. Beyond that, the call is difficult. What might appear heroic might also create more harm than good. Thus, while some may exceed minimum expectations and become good citizen Samaritans, or even splendid Samaritans, we should all remain aware, nonetheless, that in times of peril, both in our own interest *and* in the interest of those who assist us, there are minimal expectations of citizen Samaritanship that none of us should fall below.

References

1. Clark CC. In harm's way: AMA physicians and the duty to treat. *J Med Philos*. January 2005; forthcoming. View Article PubMed Google Scholar
2. DeGuerre C. Case in health law. Good Samaritan statues: are medical volunteers protected? *Virtual Mentor*. April 2004. Thomson's distinctions are explained and cited in note (1) above.
3. Simon JG, Powers CW, Gunnemann JP. The responsibilities of corporations and their owners. In: Beauchamp T, Bowie N. *Ethical Theory and Business*. 5th ed. Upper Saddle River, NJ: Prentice Hall; 1997:61-66. See also reference (1) above for a discussion of the factors.
Google Scholar

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