What Every Litigator Needs to Know About the Illinois Good Samaritan Act

2005 will mark the fortieth year that physicians can avoid civil liability in applicable situations. Over the course of those forty years, culminating in the current Illinois Good Samaritan Act (745 ILCS 49/1, et seq., and hereinafter referred to as the “GSA”), significant expansion has occurred offering protection to even more professionals. While these individuals are now protected collectively under the GSA, the roots of the statute trace back to physicians, and all Illinois case law on the GSA revolves around that profession. If the standard in those cases is to be the benchmark for the protection of other qualified professionals, the law truly does appreciate those wishing to help those in peril, for the protection of physicians continues to grow to this day.

A. History of the Good Samaritan Act

1. Early History of the Illinois Good Samaritan Act

In June 1965, the Illinois General Assembly heeded the concern of physicians who, among other things, hesitated to aid those in car accidents for fear of malpractice suits. Within the Illinois Medical Practice Act (now at 225 ILCS 60/1, et seq.), the legislature added a law that mandated:

[a]ny person licensed pursuant to this Act, or any person licensed to practice the treatment of human ailments in any other state or territory of the United States, except a person licensed to practice midwifery, who in good faith provides emergency care without fee at the scene of a motor vehicle accident or in case of nuclear attack shall not, as a result of his acts or omissions, except wilful or wanton misconduct on the part of such person, in providing such care, be liable for civil damages. Blanchard v. Murray, 331 Ill. App. 3d 961, 966-67, 771 N.E.2d 1122, 1126 (1st Dist. 2002), citing Ill. Rev. Stat. ch. 91, par. 2(a) (1965).

As stated, this version only protected physicians and over the next eight years, the legislature extended the immunity available to them even more. In 1969, any physician who provided emergency care “to a victim of an accident” rather than a victim of a motor vehicle accident would not face liability. Effective in 1973, a new prerequisite to protection mandated a physician not have “prior notice of the illness or injury” at issue, but the same amendment eliminated the need for an “accident” or “nuclear attack” altogether. By the end of the 1970s, a physician was required to only provide “emergency care” for no fee and without prior notice to receive immunity. Ill. Rev. Stat. ch. 91, par. 2(a) (1973).

Throughout the 1980s and early 1990s, this remained the case. The only major alteration was a transfer to then chapter 111 of the Illinois Code with the rest of the Medical Practice Act. However, sweeping change was on the horizon.
2. Good Samaritan Physicians Get a New Home and New Neighbors

The biggest event in the history of the GSA occurred in 1996, when Public Act 89-607 was signed into law. Its contents were effective on January 1, 1997, and among other things, the prior law protecting physicians became part of an entirely new act protecting numerous careers that were now eligible for immunity from civil liability. This collection of professions collectively formed the new GSA, located at 745 ILCS 49/1, et seq.

The General Assembly noted in P.A. 89-607 (and does to this day in 745 ILCS 49/2) that Illinois has “numerous protections for the generous and compassionate acts of its citizens who volunteer their time and talents to help others.” P.A. 89-607; 745 ILCS 49/2. It opined there was a need to recodify all prior protective laws into one section. (For example, prior laws granting immunity to certain professionals in other sections now state civil liability is precluded “as provided in the Good Samaritan Act.” See 50 ILCS 750/15.1). The legislature also felt the GSA was to be “liberally construed,” which in future years became very important to physicians involved in litigation. P.A. 89-607; 745 ILCS 49/2.

P.A. 89-607 not only combined existing protections available to certain Samaritans, but also included new professions as well. The bottom line is that each of the following professionals would now be immune from civil liability if the conditions unique to that profession per its relevant statute were met, and the acts or omissions taken were not considered willful and wanton:

1. Emergency telephone workers (currently at 745 ILCS 49/5);
2. Those trained in cardiopulmonary resuscitation (745 ILCS 49/10);
3. Dentists who provide emergency care at an accident scene (745 ILCS 49/15);
4. Dentists who provide their trade at a free dental clinic (745 ILCS 49/20);
5. Nurses who receive compensation in providing emergency care (745 ILCS 49/35);
6. Nurses who do not receive compensation (745 ILCS 49/40);
7. Physical therapists who provide emergency care (745 ILCS 49/45);
8. Podiatrists who provide emergency care (745 ILCS 49/50);
9. Respiratory care practitioners (745 ILCS 49/55);
10. Veterinarians (745 ILCS 49/60);
11. Those assisting victims that are choking at a restaurant (745 ILCS 49/65);
12. Law enforcement officers and firemen (745 ILCS 49/70); and
13. Employers and employees under the Health and Safety Act (820 ILCS 225/.01 et seq.), (745 ILCS 49/75).

As noted earlier, physicians also were protected in this new GSA, and the provision granting them immunity in proper situations was now located at 745 ILCS 49/25. The revised § 49/25 stated:
[a]ny person licensed under the Medical Practice Act of 1987 or any person licensed to practice the treatment of human ailments in any other state or territory of the United States, except a person licensed to practice midwifery, who, in good faith and without prior notice of illness or injury, provides emergency care without fee to a person, shall not, as a result of their acts or omissions, except willful or wanton misconduct on the part of the person, in providing the care, be liable for civil damages. P.A. 89-607.

In addition to protecting physicians in general, 89-607 also extended protection to those in the profession that in good faith and without a fee provided treatment and other medical services in an established free medical clinic. P.A. 89-607; 745 ILCS 49/30. Immunity was also granted to hospitals and other health care providers that provided further treatment and other medical services upon referral from such a clinic. Id.

Again, these professionals would also be granted immunity unless while otherwise meeting the requirements, their acts or omissions were deemed to be willful and wanton. P.A. 89-607; 745 ILCS 49/1, et seq.

3. Other Recent Legislation

The General Assembly continued to amend the GSA in more recent years in both technical and substantive fashions. For example, more professionals were granted immunity in the proper circumstances. Today, the group now also includes:

1. Advanced practice nurses providing emergency care (745 ILCS 49/34);

2. Optometrists providing emergency care (745 ILCS 49/42);

3. Those trained in emergency care of a person in cardiac arrest that included training on an automatic external defibrillator. (745 ILCS 49/12);

4. Physician assistants (745 ILCS 49/46); and

5. Individuals who work at free medical clinics (besides physicians): advanced practice nurses, physician assistants, nurses, pharmacists, physical therapists, podiatrists, or social workers. (745 ILCS 49/30).

During this time, changes continued to be made to the section protecting physicians as well. While the exception was lifted for a person trained in the practice of midwifery, the most important language removal was the cancellation of the requirement that a physician not have “prior notice of the illness or injury.” Thus, the statute then read as it does today:

[a]ny person licensed under the Medical Practice Act of 1987 or any person licensed to practice the treatment of human ailments in any other state or territory of the United States who, in good faith, provides emergency care without fee to a person, shall not, as a result of his or her acts or omissions, except willful or wanton misconduct on the part of the person, in providing the care, be liable for civil damages. 745 ILCS 49/25.

The removal of this language effective in the late 1990s will continue to prove very important for those physicians who face future litigation and claim immunity under the GSA. After all, one less
requirement means protection is more easily attainable. It is worth noting nurses had the exact same language stricken from their statute as well, creating greater protection for them, too. See 745 ILCS 49/35.

B. Applying the Good Samaritan Act in the Courts

Despite the existence of numerous careers in the GSA, as noted earlier, Illinois courts have only decided cases dealing with just one - the physician. Indeed, there are not even many cases dealing with physicians. Based on the holdings in these decisions, it would seem likely a Good Samaritan in any profession could defend an action brought against them using the same basic theory: following and meeting the prerequisites that are easily drawn from the clear meaning of their statute. Almost every physician that has requested immunity has received it, and those that prevailed did so because the courts followed the plain meaning of their statute.


In the first case of its kind in Illinois, the First District of the Appellate Court analyzed the strength of the GSA as it applied to physicians. A pregnant woman was admitted to a hospital under the care of her own physician, after complaining of numbness and pain in her leg, hyperventilation, and chest pain. Johnson, at 910. She was 37 weeks pregnant at the time. Several days later, she experienced respiratory and cardiac arrest, and the defendant-doctor, who was attending to one of his own patients, was summoned by nurses. Id.

Defendant attempted respiratory and cardiac renunciation until the woman’s “code blue” was sounded, both she and her child were pronounced dead. Id., at 910-11.

The administrator of her estate brought suit against the defendant and others, but the defendant asserted no civil liability could be imposed pursuant to the GSA (at the time, Section 2a of the Medical Practice Act, ch. 111). Id., at 911. The trial court granted summary judgment, for inter alia, the GSA was applicable under these circumstances to emergency situations in a hospital. Id.

The First District affirmed the trial court, even if summary judgment was premature. Id. at 916. The court noted the issue of whether the GSA applies to a physician responding to an emergency in a hospital was one of first impression in Illinois, although it had been weighed in other states. Id. at 916-17. It found the statutory language was clear and not ambiguous, and therefore exceptions, limitations, and conditions should not be read into it. Id. at 917, citing People v. Goins, 119 Ill. 2d 259, 518 N.E.2d 1014 (1998).

The court surmised it was beyond its power to limit the ordinary meaning of the word “emergency” by adding “except when occurring in a hospital.” Id., at 917. The court felt any change in the scope of the statute’s protection is within the realm of the legislature, not that of a court. Id.

In the court’s opinion, if all other conditions stated in 2a were met (a physician who, in good faith, rendered emergency care without charging a fee without prior notice of the illness), as was the case here, no liability would exist. Id. at 918. Thus, the defendant’s motion for summary judgment was granted.

While not expressly laying out a test, the court issued a mandate to future reviewing courts to check for all prerequisites under the statute before ensuring physicians were qualified for immunity under the GSA. As seen in future cases, and based on the clear language of the GSA as it existed prior to 1998, meeting all other conditions stated in 2a (now 745 ILCS 49/25) became a three-part test requiring: (1) the doctor must not have notice of the illness or injury; (2) the doctor must provide emergency care; and (3) the doctor must not charge a fee.

Only three years later, the First District received the opportunity to expound on its test in detail and apply it to another set of somewhat similar facts.

In Roberts, a woman was rushed to a hospital. Id. at 410-11. She had been under the care of her personal obstetricians, but at some point, they left the hospital, and care was given by other hospital nurses and resident doctors. Id. at 411.

Defendant-doctor cared for his own patients that afternoon. Id. However, a nurse later informed him there were decelerations in the fetal heart tones of the woman’s baby at issue in the case. Id. Defendant did not perform any emergency care at the time, and only did when a resident who had been caring for the woman requested immediate assistance after heart tones were reported to have been lost. Id. A nurse had seen the defendant in the doctors’ lounge and brought him in to the delivery room. Id. Eventually, the child was born, but with quadriplegia and cerebral palsy after a mid-forceps delivery. Id.

The trial judge granted summary judgment for the defendant on the ground he was immune pursuant to the GSA. The First District affirmed. The court laid out the three-part test it had implied in Johnson, and formally applied it to the facts of this case.

Under the first part of the test, the court had to determine if the defendant had notice of the illness or injury. Id. at 415. It was alleged the defendant had notice because he had several contacts with the woman before he delivered the child. Id. The record showed the defendant was informed by a nurse that the electronic monitor indicated decelerations, but nothing showed whether the nurse actually gave him the tracing strip or just verbally passed along her observations. Id. at 416. Other facts corroborated the lack of notice, including the defendant’s reliance on four examinations by prenatal attending doctors indicating normal cephalic presentation (to defeat plaintiff’s argument the fetus was in breech and thus a high risk patient per the junior house officer’s notations), and that the defendant had retired to the doctors’ lounge after performing a routine vaginal examination, feeling there was no indication any significant abnormality existed until the time heart tones were reported to have been lost. Id. at 416-17.

The court then moved to part two of its test to see if the defendant provided emergency care. Id. at 417. Unlike Johnson, there was no “code blue,” but the court felt there was “no question that an emergency existed when the nurse failed to hear fetal heart tones.” Id. The resident doctor deemed it necessary at that time to obtain immediate assistance from another doctor. Id. Defendant provided that assistance and performed a mid-forceps delivery, one of the fastest techniques available. Id.

Finally, the court had to determine if the defendant received a fee for his services. Id. The facts showed the defendant did not receive a fee for delivering the child and had no knowledge his employer received one either. Id. at 417-18. Therefore, the court held no questions of fact precluded the application of the statute.


Again, the First District was faced with a defendant-doctor claiming immunity under the GSA, in yet another case with similar facts. The plaintiffs alleged, inter alia, the defendant committed malpractice during the course of the delivery of their premature infant which allegedly resulted in its death. On the day in question, the defendant was in the hospital attending another patient of his who was in labor. Id. at 85. The on-call obstetrician never responded to attempted contact made by nurses helping the plaintiff-mother. Id. Therefore, shortly before delivery, the labor room nurse contacted the defendant, who had never met the mother before her delivery. Id.

Defendant had no idea how much time had passed since the mother first came into the emergency room. Id. Only minutes after the defendant’s arrival in the delivery room, the baby was actually delivered. Id. The trial court granted the defendant’s motion for summary judgment, and the First
District affirmed, again using the three-part test from Johnson, but this time focusing on part three as to what constituted “without a fee.”

Preliminarily, the court held the defendant had no notice of the illness or injury. He had never seen the mother prior to the date of delivery, and nothing contradicted the fact his examination of her just prior to the delivery was the first knowledge he had a premature birth was imminent. Id. at 91.

Secondly, the court held the situation was an emergency. The plaintiffs presented no evidence to dispute another doctor was on-call that evening, and that the defendant was asked to take over since no response was received from the doctor on-call. Id. at 91-92. The facts showed the mother had such severe labor pains that night she had to go to the nearest hospital, one at which her own doctor was not present. Id. at 92.

The court then addressed the issue whether the defendant did or did not receive a fee for his services. The plaintiff argued he did since his office had sent out a request for the plaintiffs’ public aid number to receive compensation. Id. However, even though such a request was sent per standard operating procedure at the defendant’s office, nothing was ever produced to indicate a bill was sent to either the plaintiffs or public aid. Id.

The court held the fact the letter was sent is a red herring, since the statute mentions nothing of intent. Id. Therefore, even if the letter could be construed as an intent to bill in the future, no bill was ever sent nor payment provided, and thus those facts must control. Id.


On this occasion, the First District had to further analyze the second part of the Johnson test to see if not only the physician had provided emergency care, but also to determine exactly what constitutes an emergency.

In this case, the defendant-doctor treated a minor child for a foot infection when his aunt (who had legal custody) brought him to the defendant’s office. Id. at 643. Originally, the defendant was seeing one of the aunt’s children and she also asked if he would examine the other for infected feet. Id.

The defendant noted seeing the other child made him an “add on” and that examining him was “sort of” an emergency since the aunt’s request could be seen as such. Id. The defendant did not charge for the visit because the aunt did not have any money and she did not have a public aid card. Id. at 644. The child made several more visits to the defendant’s office for various illnesses in the future, including continued problems with his feet.

Eventually, the defendant learned from his attorney the aunt’s husband had been abusing her and the children in their custody. Id. A lawsuit was filed by the child’s mother, alleging medical malpractice against the defendant, in that he failed to take an adequate history or perform an adequate examination of the child, failed to record signs of child abuse, and failed to report suspected child abuse as required under Illinois law. Id. at 643.

The trial court granted the defendant’s motion for summary judgment for it felt he was immune from liability under the GSA. The defendant pointed out that nothing during examination manifested itself as evidence of abuse, and the court used the three-part test from Johnson to determine immunity was proper. The trial court determined the illness or injury was the purported child abuse and the defendant had no notice of it, received no fee, and that both the aunt and the defendant had classified the visit as an emergency.

The First District, in its analysis, acknowledged the plaintiff did not contest and admitted the fact the defendant had no notice of the injury or illness. Id. at 647. Therefore, only the other two parts of the test were left. The court eventually conceded these factors favored the defendant as well, and affirmed the trial court.
The court first recalled its decision in Villamil regarding payment for services, to extinguish the plaintiff’s argument the defendant had received compensation. *Id.* at 648. Whatever the defendant’s intentions were with respect to possible billing in the future for his services, they were still deemed irrelevant. Also, even though the plaintiff contended the number of times the defendant treated the child is material in regard to billing to show anticipated payment, the court rejected that argument as well. *Id.* There was no authority to support that position and like the issue of intent, the defendant’s expectations were irrelevant.

Concerning the remaining part of the test, the plaintiff contended the trial court erred in relying on a case from Oklahoma to define the word “emergency.” *Id.* at 650, discussing *Jackson v. Mercy Health Ctr.*, 864 P.2d 839 (Okla. 1993). The plaintiff urged the court to adopt the definition of “emergency” in the dictionary and to limit the conditions to those defined in medical literature. *Id.* at 649.

The court noted no Illinois case addressing the GSA had defined emergency or emergency care. Only three cases had defined it, but in unrelated contexts. *Id.* However, several other jurisdictions addressed the definition with specific reference to Good Samaritan laws, and the court took the opportunity to analyze them as well as medical dictionaries. *Id.* at 649-50.

Essentially, the court rejected the plaintiff’s request to define “emergency” with a bright-line rule. *Id.* at 651. It stated there are a variety of situations which may equate to emergency care under the facts of one case, yet may not fall within any specific definition and may not be identified in medical literature as such. *Id.* Thus, a flexible broad definition was adopted, “given the purposes of the Good Samaritan Act and the need for medical providers to intervene and take care of individuals under a variety of situations without the threat of liability.” *Id.*

The court held that rather than a bright-line rule, whether an emergency exists is to be resolved “based on the unforeseen, unexpected combination of circumstances presented which require the need for immediate action, assistance or relief.” *Id.* Based on that definition, the court concluded that the defendant was presented with an emergency. The child had inflammation and more importantly, an infection in his feet that required immediate attention, which could have easily turned into a more serious and severe infection absent treatment. *Id.*

It is worth noting the claim relating to reporting the abuse was deemed to be waived by the court since the plaintiff had failed to raise the issue in the trial court. *Id.*


Just one year after *Rivera*, the First District found a physician would not be able to successfully prevail on his motion for summary judgment based on the GSA. Plaintiff-mother, on behalf of her son, filed suit against numerous parties, including the defendant-doctor, alleging negligence in her son’s delivery. *Id.* at 963. The trial court granted the defendant’s motion for summary judgment based on immunity pursuant to the GSA. The plaintiff contended the lower court erred, and the First District reversed.

The plaintiff was admitted to the hospital with labor pains. *Id.* The defendant was contacted at home to perform a cesarean section delivery on her since he was on-call. *Id.* at 964. During the course of the delivery, the baby suffered an injury to his right ring finger. *Id.*

The plaintiff had arrived at the hospital around midnight and was later informed an emergency cesarean section would have to be performed because the baby’s heart rate was dropping. *Id.* She testified the defendant, who to her knowledge was on-call, entered her room and said he would be performing the operation. *Id.*

After the birth of the baby, the plaintiff first recalled being awakened by a nurse who said something had happened and that the baby had been transferred to another hospital. *Id.* The defendant
later told the plaintiff the baby was cut when he threw his right hand up during the course of the cesarean section. *Id.*

The defendant testified the plaintiff was not a regular patient, had not seen her before the date of the incident, and he did not conduct any follow-up. *Id.* at 965. He further stated he did not charge for medical services because he was there as a service to the hospital in support of its residency program, and he was not a regular on-call physician and unsure why he was called that night. *Id.*

The appellate court noted the changes the GSA had undergone throughout the previous decades, and noted the post-1998 amendment (eliminating the requirement that a physician have no prior knowledge of an illness or injury) did not apply since statutes are presumed to apply prospectively, and the alleged actions in this case took place before the amendment took effect. *Id.* at 967.

Before fully applying the *Johnson* test, the court first noted the four cases (those previously discussed in this article) in Illinois addressing the GSA within the context of an emergency within a hospital. *Id.* at 970. The court conceded this application may not be consistent with what the legislature may have intended, but the plain language of the GSA justifies its application to emergencies in hospital settings. *Id.* A review of the previous holdings revealed the court has “indeed liberally construed the plain language of the Act” as the legislative purpose requests. *Id.*; 745 ILCS 49/2.

The court compared the facts in this case with the previous four cases, and by applying those decisions and the plain language of the GSA to the case at bar, the court found it “clear that it *does* matter whether [defendant] was on-call when he responded to [a] request for assistance.” *Id.* at 972 (emphasis added). Upon receiving a telephone call at home where he was told of the nature of the plaintiff’s illness, then electing to leave home, driving to the hospital and performing the surgery, such actions constituted “prior notice of the illness.” *Id.*

The court noted the facts in this case were “extremely” different than previous cases. In those instances, immediate, critical concerns presented themselves. *Id.* The court felt this was true even in *Roberts*, where the doctor examined the patient 18 minutes after first being told of a deceleration and began delivery 10 minutes afterward. *Id.* The court pointed out 76 minutes passed from first contact with the defendant here to the time the caesarean section began. *Id.*

Unfortunately for the defendant, the court realized that if the delivery had occurred after the 1998 amendment of the GSA took hold, the lack of prior notice would no longer be a prerequisite to receiving immunity from civil liability. *Id.* at 972-73.

While the defendant’s motion was defeated, the court still took it upon itself to continue its analysis under the *Johnson* test since so little case law exists. *Id.* at 973. In deciding the situation was an emergency, the court again noted a bright-line definition and rule was inappropriate. *Id.* It felt in determining whether there was an emergency, “the trier of fact must consider the gravity, the certainty, and the immediacy of the consequences to be expected if no action is taken.” *Id.* at 974. The court also solidified its earlier stance that no requirement in the GSA mandates a court to look at the intent behind not charging a fee for services. *Id.* Here, the defendant was working to help the residency program versus volunteering to help patients. *Id.* But, since intent is not the issue, the defendant passed the third part of the test as well, and would have been granted immunity if the events occurred after the 1998 amendment took hold.


In 2004, the Second District of the Appellate Court weighed in on the GSA in two separate decisions, which were related to child-birth as well. The outcomes show that the First and Second Districts are not in conflict regarding the GSA.
Somoye involved yet another defendant-doctor who arrived at the labor and delivery unit of a medical center to deliver the baby of one of his patients. *Id.* at 211. He did not anticipate treating the plaintiff and was not aware of her condition. *Id.* About 15 minutes after he arrived, another doctor asked him in the hallway to recommend a course of action for his patient based on a brief description, since the on-call obstetrical consultant could not be reached. *Id.* Defendant made several recommendations, and then returned to his own patient. *Id.*

About two hours later, the same doctor again encountered the defendant in the hallway and asked for help in evaluating the plaintiff’s condition. *Id.* Defendant was told the attending physician (who was at home) recommended the baby be delivered that night. *Id.* He examined the patient and determined a cesarean section was necessary, advised the plaintiff of this, and told the other doctor he would deliver the baby if no other obstetrician was available. *Id.* He delivered his patient’s baby about an hour later and then delivered the plaintiff’s baby two hours after that. *Id.* It was found that the plaintiff’s child suffered from cerebral palsy, seizure disorder, and developmental delay, and thus the plaintiff filed suit alleging negligence on the part of several parties, including the defendant. *Id.* at 211-12.

At the time of the alleged malpractice in the suit, the pre-1998 GSA was still in place, and the court therefore concluded the three-part test from *Johnson* was required. *Id.* at 212-13. The court noted it was undisputed the defendant did not charge a fee for his services. *Id.* at 213. The plaintiffs contended questions of fact only existed regarding the other two factors. *Id.*

The Second District distinguished this case from the *Blanchard* decision in concluding the defendant did not have notice of the plaintiff’s condition, and agreed with him in that the facts are more like those in *Roberts.* *Id.* at 213-14 He was not the on-call obstetrician, and was present only to deliver the baby of one of his own patients. *Id.* at 214. The first encounter he had with the other doctor in consultation was brief, and he did not examine the plaintiff or even learn her name. *Id.* He answered questions in hypothetical terms and suggested a particular test to better ascertain her condition. *Id.* He delivered the baby only after the other doctor told him the attending physician recommended a cesarean be performed. *Id.*

Examining the “emergency” requirement, the court looked at the First District’s discussions of the issue in *Rivera*, and expanded on its general sentiment to help in dispensing with the plaintiff’s negligence claim against the defendant. *Id.* at 215.

The court held that if no emergency existed, the plaintiff’s underlying negligence claim failed regardless of the GSA because it was alleged a negligent failure to act, *i.e.*, to deliver the baby promptly, caused injury. *Id.* at 216. It is undisputed the defendant only had “privileges” at the hospital, and thus, no physician-patient relationship existed and the defendant owed no duty to the plaintiffs before the delivery. *Id.* Conversely, if an emergency existed, the underlying negligence claim survives but the GSA immunizes the defendant because he had no notice of the injury and did not charge a fee for his services. *Id.*


In the most recent case regarding the GSA, a defendant-doctor had finished her elective surgical cases one afternoon and went home, only to be called back to provide anesthesia service for a patient in labor. *Id.* at 888. At the same time, other members of the hospital staff were in a nearby labor and delivery room attempting a forceps delivery of the plaintiff’s child. *Id.* Defendant was unaware of this delivery or of the ensuing complications. *Id.*

The doctor performing the forceps delivery did not alert the on-call pediatrician of complications with the plaintiff’s delivery in time for him to be present to treat the newborn after birth, and monitors noted the child’s heart was in distress. *Id.* Since the on-call physician was not available, the doctor requested that the defendant assist in the child’s neonatal resuscitation (“NNR”). *Id.* Defendant was
paged, and was not told why, but still arrived and participated in the remainder of the NNR. *Id.* She ended up being the only physician involved in the NNR and was, as such, in charge. *Id.* at 888-89.

Cardiac activity was achieved two minutes after birth, the child was stabilized, and then airlifted to a different hospital. *Id.* However, permanent damage had already occurred.

In the plaintiff’s amended complaint, the defendant was added on the basis the delay in regaining cardiac and respiratory activity was due to her negligent performance of the NNR. *Id.* Defendant moved for summary judgment, raising the GSA, and the trial court granted the motion. *Id.*

The Second District again noted the GSA was amended in 1998, but concluded since this incident occurred prior to that time, prior notice would still be a part of the test to determine if immunity was properly found. *Id.* at 890.

However, the plaintiff did not dispute the defendant satisfied all of the elements in favor of immunity. *Id.* Instead, it was maintained that in a case where a physician has a particular employment contract requiring her to render resuscitation, or in other words, a preexisting duty to render such care to patients, the aid offered is not “voluntary” in the sense of a Good Samaritan, and defeats the purpose of the GSA. *Id.; 745 ILCS 49/2.* The plaintiff argued the GSA only applied to those who volunteer their services and thus a court must address the additional element of whether the person claiming immunity was a “volunteer” with no preexisting duty to render care to the patient. *Id.* at 891.

The appellate court opined that the courts have liberally construed the plain language of the GSA (as required by 745 ILCS 49/2), and thus have applied it to emergencies at hospitals with physicians who allegedly had preexisting duties to assist. *Id.* The court found the plain language of 745 ILCS 49/25 contained no requirement for a physician to prove the absence of a preexisting duty to the patient, and thus, even though the legislature indicated its intent to foster volunteerism, it did not expressly require a doctor to be a volunteer to be granted immunity. *Id.* As it was written, the law at that time only required no notice, emergency care, and no fee, and thus it was apparent the legislature intended to protect physicians who render emergency medical care from malpractice lawsuits. *Id.*

Based on the “clear language,” the court concluded (in apparent agreement with the First District) since a “physician need not prove the absence of a preexisting duty to render aid to the patient in order to be immunized,” the on-call status of a physician is only relevant in terms of the notice requirement. *Id.* at 894. Here, the defendant had no prior notice, and thus summary judgment was proper since all parts of the test were met. *Id.*

*In dicta,* the court reiterated it was clear the GSA grants immunity to encourage physicians to give aid without fear of repercussions in courts. *Id.* Upon amending the act in 1998, the legislature had the opportunity to limit the GSA’s protection to doctors who had established the absence of a doctor-patient relationship or a preexisting duty, but instead removed the notice requirement and broadened, rather than limited, the application. *Id.* The court noted it must apply the GSA as written, and any change must be done by the legislature. *Id.*

**C. Conclusion**

Unless the General Assembly amends the GSA, it appears the 1998 amendment to 745 ILCS 49/25 will give Good Samaritan physicians a broader shield with which to protect themselves from the malpractice and negligence swords. Individuals from other professions should adhere to the same basic theories and principles physicians have undertaken to successfully immunize themselves from liability - they should make sure they follow the clear language of the part of the GSA that applies to them. While it may be more difficult for them to prevail since some of their standards are still stricter than the physicians, they too can still realize the fulfillment of aiding a fellow human in peril without fear of retribution in sharing their talents and gifts if proper precautions are considered.
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