Resuscitation Council (UK)

The legal status of those who attempt resuscitation

Contents

Throughout this publication the masculine is used to denote the masculine or feminine.

Introduction

There is understandable concern that individuals who attempt to resuscitate a casualty in a state of cardio-pulmonary arrest may be at risk of having a claim brought against them if that casualty suffers harm as a result of their intervention. The advent of the automated external defibrillator (AED) has heightened this anxiety because these devices are increasingly used by members of the lay public who have not had the benefit of formal medical training.

It is, unfortunately, extremely difficult to give any definitive advice on this subject partly due to the absence of any legal precedent and partly due to the difficulty of predicting what sort of harm might actually be suffered as a consequence of any attempted resuscitation. This document seeks to clarify, as far as possible, the potential legal liability of those individuals who choose voluntarily to intervene in emergency situations to carry out life-saving resuscitation procedures on others.

Broadly speaking there are two kinds of legal duty to which citizens in the UK are subject; those imposed by Parliament which are known as statutory duties and those imposed by the common law - the law that has been built up over the centuries as a result of decisions made by judges in court. There are no statutory duties relating to the field of resuscitation, but potential liability can arise at common law.

Although there have been a few cases in the United Kingdom where a claim has been brought against a "rescuer", there have been no reported cases at a where a casualty has successfully sued someone who came to his aid in an emergency. A claim might therefore, in theory, be brought against a rescuer either in the law of trespass on the grounds that his intervention constituted as assault on the casualty, and / or in the law of negligence for a breach of his duty of care towards the casualty. Potentially there could also be liability for assault in criminal law, but this document will concentrate purely on principles of civil liability and claims for compensation. A claim could be brought either by the casualty or, should they die, by their estate, and if the actions of the rescuer led to serious personal injury or death, a very large payment of damages by way of compensation could in theory be ordered by the court.

A claim for trespass against the person - assault / battery

A claim may be brought against a rescuer for what is commonly known as assault but, more accurately, described as battery. Battery is a form of trespass against the person that is actionable in itself. In other words, in order to succeed in a claim, the victim does not have to show that he has suffered any actual harm, although it would be necessary for him to show this if he was to be awarded any more than a minimal compensatory sum. Battery is the "infliction of unlawful personal force upon another". Force, which can include even light touching, is unlawful if the person upon whom it is exerted has not given his consent to it. In the context of resuscitation, the contact involved in performing a procedure or in using an AED could clearly constitute a battery since, if the casualty is in cardio-pulmonary arrest and unconscious, he will clearly not be in a position to consent to being touched.

This situation is not uncommon in professional medical practice, where there are two primary defences available to a doctor or nurse who carries out medical treatment on a patient who has not expressly consented to it. The first is the defence of "implied consent", the justification behind which is that if the person were conscious and able to make a decision, he would consent to the procedure. The second primary defence to any action for trespass against the person is that of "necessity". The reasoning here is that treatment without consent can be considered lawful if it is given in the best interests of the patient; in other words, if it is necessary to save his life or to improve or prevent the deterioration of his condition. There has been some controversy about whether this is a defence which does in fact exist in English law. In one famous House of Lords case, however, the judge stated "that there exists in the common law a principle of necessity which may justify action which would otherwise be unlawful is not in doubt". Both defences could, it would seem, be comfortably extrapolated to the emergency situation where immediate treatment to save life is required off hospital premises.

There are likely, however, to be limitations on the application of these defence when procedures are carried out by non-professional rescuers and the less well trained the rescuer the harder it may become to justify either defence. It becomes more difficult, for example, to argue that an unconscious person has given implied consent to a (relatively) untrained person performing what is in effect a medical procedure, notwithstanding that the procedure may be straightforward, automated and mechanical. Similarly, it may be harder to argue that treatment by a lay person is in the best interests of the casualty. Only if the action taken by a lay person is, under all the circumstances, 'reasonable' and in the best interests of the assisted person, is there likely to be a defence. Given the simplicity of the AED and its reliability, a lay person may well be justified in using one in an emergency situation when a more qualified person is not available. On the other hand, intervention may not be considered 'reasonable' if another more highly trained person is available and willing to act.

A claim for negligence

In order for a claim of negligence to succeed a casualty would have to show that the rescuer owed him a duty of care which he breached, thereby causing him to suffer foreseeable harm.

The duty of care

In the United Kingdom, there is generally no legal obligation on an individual b assist a person in need of resuscitation provided he was not the cause of the casualty requiring treatment. In other words, there is generally no legal liability for a mere omission to act. This is different

from the situation in many other European countries where the law does in certain circumstances impose a duty to help others.

There are a limited number of relationships where courts in the United Kingdom have found that a positive duty to protect another person exists. For example, a case in 1978 held liable a student ice-cream seller who failed to warn a 4 year old child of the danger of an oncoming car. Other relationships which would be likely to fall within the same bracket would be that of a parent or teacher for the safety of a child, of a doctor or nurse responsible for the health and well-being of a patient under their professional care, or of a police officer under a duty to render help to the public as part of his job description.

The situation may also be slightly different if the casualty is a work colleague (a work place first-aider. Under the Health and Safety at Work Act 1974 and the subsequent Health and Safety (First Aid) Regulations 1981, an employer is under a statutory duty to provide first-aiders in the work place for the benefit of his employees. These first-aiders must undergo training to an approved standard in a specified list of competencies. As such, an individual who takes on this role as part of his job description could be argued to owe a duty of care to his fellow employees to render first aid.

A person, whether a health care professional or a member of the lay public who witnesses a situation 'on the street' where resuscitation might be required is under no obligation to assist provided the situation was not caused by him. However, if that person does choose voluntarily to intervene to render assistance he will assume a duty of care towards the individual concerned.

Whether intervening under a positive duty of care or under an assumed duty c care, a person who attempts resuscitation will only be legally liable if the intervention leaves a casualty in a worse position than he would have been in had no action been taken at all. It is difficult in the circumstances under consideration to see how a rescuer's intervention could leave a casualty worse off since in the case of cardio-pulmonary arrest a victim would, without immediate resuscitation, certainly otherwise die. Furthermore, if an AED is being used, it will only permit the administration of a defibrillatory shock when its sophisticated electronic algorithms determine that ventricular fibrillation is present and, since patients in this state are actually clinically dead, it is unlikely that any intervention with this device could make any situation worse.

If resuscitation is being carried out without an AED, however, it is slightly easier to envisage how the intervention of a rescuer might potentially leave a casualty worse off. For example, if a rescuer inappropriately administered chest compressions which caused damage to his chest wall or underlying organs, he would be causing damage which the casualty would not otherwise have suffered and, given that the casualty was not in cardio-pulmonary arrest and therefore not in need of emergency resuscitation, would by his intervention be leaving him in a worse position.

It is possible that the family of a casualty who has been revived by resuscitation but who has been left in a permanent vegetative state, might attempt to pursue a resuscitator for damages on the grounds that the casualty has been left worse off as a result of his intervention, arguing that it would have been preferable if he had died rather than been left brain-damaged for life. However, in this country, legally and as a matter of public policy, this type of argument (known as a claim for "wrongful life") should not succeed.

The standard of care

If a casualty is able to show that a rescuer owed him a duty of care and that, as a result of the rescuer's intervention, he has been left in a worse position than he would have been in had that rescuer not intervened, he will still have I show the court that the standard of care

employed by the rescuer in performing the resuscitation procedure was inadequate and that it was for this reason that he was left in a worse position.

The standard of care to be expected of a health professional, of a non professional first-aider and of a member of the general public necessarily differ.

Members of the health-care professions who attempt resuscitation will be expected to employ the highest professional standard of care, compatible with their position in the health service and with their level of training. Their level of competence will be judged on an objective basis and they could therefore be held liable if that standard of care falls below that to be expected of a reasonably competent health professional of the same qualifications and experience. Therefore, provided resuscitation procedures are performed correctly and in accordance with current guidelines it is unlikely that a reasonably competent health professional of the same qualifications and experience. Therefore, provided resuscitation procedures are performed correctly and in accordance with current guidelines it is unlikely that a successful claim could be brought. Liability is only likely to arise if procedures are carried out incorrectly and with disregard to accepted practice and guidelines.

A 'non-professional' first-aider or other member of the lay public who attempts to resuscitate someone will not be expected to employ the same standard of care as a health care professional. Liability will only arise if the standard of care employed falls below that to be expected of a reasonably careful person in the rescuer's position. For practical purposes, this means that if an action were brought against a non-professional the court would be likely to take into consideration the fact that the first-aider had a skill (having been trained in resuscitation techniques I in the use of an AED), but would also acknowledge the fact that the individual was a volunteer first-aider and not a professional health-care provider. If the procedure is performed correctly and in accordance with current practice and guidelines, it is unlikely that a successful claim for negligence could be brought. However, if the procedure is carried out incorrectly, with disregard for modern accepted practice and current recommendations, it is possible that liability could arise.

A member of the general public with no special resuscitation training will only be considered negligent if he performs an act that a reasonable and prudent man in his position would not have done in the same situation, or omits to do something which a reasonable man would have done. The standard by which he will be judged is therefore even lower than that of a non-professional first- aider.

In summary, a person who attempts resuscitation will only be liable for damages if negligent intervention directly causes injury which would not otherwise have occurred or if it exacerbates an injury. In the circumstances under discussion, where without resuscitation the casualty would almost certainly die, the risk of incurring such liability is extremely small. If, however, resuscitation procedure is carried out negligently and a consequential injury can be proved to have arisen from that negligent procedure, a rescuer may be held liable for substantial damages if the standard of care he employed fell below that which could be expected of him in the given circumstances. This applies whether he is a health-care professional, a non-professional volunteer first-aider or simply an unskilled member of the general public.

Liability of third parties

It is possible that if a rescuer performs a procedure negligently others may, additionally or alternatively, be pursued for damages in respect of the injuries that the casualty suffers. In this context there is a potential liability for those who train rescuers in resuscitation techniques, those who provide or maintain resuscitation equipment and those who administer the system under which rescuers operate.

In the United Kingdom the Resuscitation Council (UK) publishes or endorses guidelines to assist those attempting resuscitation. Practically all professional health-care workers, voluntary aid societies and other first aid groups follow these recommendations. It is possible that a casualty might attempt to argue that, although the rescuer performed the recommended procedures correctly, the resuscitation procedure was in itself intrinsically flawed and the Resuscitation Council should therefore be liable for his consequential injuries.

This argument will fail if the procedure recommended by the Council, and employed correctly by the rescuer, is accepted as proper by a responsible body of medical opinion, even if it is a minority body of opinion. It will not be sufficient for a casualty simply to show that there exists another body of opinion that would take a contrary view. This being the case, it is highly improbable that the standards and guidelines employed and taught in the United Kingdom could be successfully challenged.

Hospitals that run resuscitation training courses for their staff might indirectly be held liable if resuscitation trainers in their employment teach a procedure which has not been approved by a responsible body of medical opinion, or if they teach an approved procedure incorrectly. However, provided their teaching is correct and in accordance with Resuscitation Council (UK) guidelines, it is, for the above reasons, difficult to envisage a claim being pursued.

The same principle applies to other bodies carrying out resuscitation training, whether in the voluntary sector or as commercial first aid training organisations. Training agencies, like hospitals, will owe a duty to train people properly and if they breach this duty by training an individual incorrectly or by certifying as competent an individual who is in fact incompetent, then they could be held liable for any consequential harm suffered by a casualty. Similarly, an organisation responsible for maintaining AEDs and auditing the maintenance of the machines might be liable if it can be shown that harm has been suffered by an individual as a result of its failure to maintain that equipment.

A new area, and one upon which it is harder again to give definitive guidance, is where an AED is purchased by a lay person or organisation outside a medically controlled system. The general principles of liability would suggest that if it is used or provided in a negligent fashion there may be liability. Therefore it could be argued that it would be negligent if the village post office for example purchased an AED and encouraged villagers to use it without providing training.

Avoiding liability

In general there are two means by which the risk of personal liability may be minimised. The first is by good practice and the second is by taking out adequate indemnity insurance.

Good practice in this context means following the guidelines recommended by authoritative bodies such as the Resuscitation Council (UK), both in the teaching and in the practice of resuscitation techniques. Training should be up to date and recommendations about re-training and refresher courses should be followed. Equipment must be of a type recommended for the procedure for which it is used and must be well maintained in accordance with the manufacturers' recommendations.

Many health care professionals will enjoy some form of protection from legal liability through NHS indemnity schemes, but in many cases such indemnity will only cover them while they are actually carrying out their role within the NHS. It may not, for example, extend to the use of AEDs off premises, and it I incumbent on the individual to be sure of the extent of their cover, particularly when volunteering for first aid duties outside their normal place of work. An analogous situation occurs with voluntary aid societies and some other first au organisations that have indemnity cover for their members whilst they are employed on the duties of the respective organisation. This cover may not necessarily apply at other times.

Trainers in resuscitation techniques who are employed by hospitals are likely to be covered by their employers' insurance. As we have seen, a hospital ma indirectly be held liable if a trainer teaches a procedure incorrectly or a procedure not recommended by a responsible body of medical opinion, It is a potential risk in respect of which NHS employing authorities should ensure the they are adequately insured. Trainers who are insured by hospitals will not necessarily be covered by their employers' indemnity insurance if they teach outside their employment. In this situation they may be covered by other insurance, for example that held by the voluntary aid body or other organisation for which they might be teaching. Again, it is incumbent on the trainers to ensure that they are protected by providing a high standard of training in accordance with modern guidelines and by having adequate indemnity cover. All organisations which teach first aid and resuscitation techniques, including the use of AEDs, should ensure they have appropriate insurance policies to cover the acts of their trainers and those trained by them

Many countries, including a number of states in the USA, have what is known as Good Samaritan legislation which gives people who provide emergency fir5 aid various levels of immunity from legal liability. It would clearly take time to effect the introduction of such legislation in the UK and it is not clear at the time of writing whether it is in fact necessary. The UK has a far less litigious culture than the USA and there is little yet to suggest that claims of this type are being actively pursued. It is, in practice, extremely difficult to envisage (and no precedent has yet been found) how a victim could successfully sue an individual who rendered him aid in an emergency situation. If anyone were to bring a successful claim, it is likely that the rescuer would have to have acted in a grossly negligent fashion and, if this was the case, it would probably not b desirable to introduce legislation to protect him.

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Document 2; Situation in America

What is the good samaritan law?

A definition of what the Good Samaritan Law doctrine is and what is its purpose. Also, what it protects against and when it is used in a tort suit.

(Tortfeasor: one who commits wrong; a wrongdoer.)

It is for this fear, that the good samaritan laws were enacted. The good samaritan doctrine as it is legally known, is a legal principle that prevents a rescuer who has voluntarily helped a victim in distress from being successfully sued for 'wrongdoing.' Its purpose is to keep people from being so reluctant to help a stranger in need for fear of legal repercussions if they made some mistake in treatment. Therefore, this doctrine was primarily developed for first aid encounters and every state does have its own adaptation of it. However, the crucial points are about the same.

Good Samaritan doctrine - Black's Law 7th edition: 'A statute that exempts from liability a person (such as an off-duty physician) who voluntarily renders aid to another in imminent danger but negligently causes injury while rendering the aid. Some form of good-samaritan legislation has been enacted in all 50 states and the District of Columbia.'

This is how the law reads verbatim. It is very straightforward as far as laws go, but there are some grey areas to it. The first questionable area is, 'unless the rescue attempt is unreasonable.' What this is referring to is when we provide care that is, by all accounts, unnecessary. Such as, removing an injured victim from a car that is not in imminent danger and the movement aggravates the injuries. Another example could be treating non-life-

threatening injuries where the condition was worsened in the attempt, splinting a broken bone. Splinting requires moving the victim so we run the risk of causing an open fracture, etc.

The other area in question, 'the rescuer acts unreasonably in performing the attempted rescue.' First of all, a person is not obligated by law to do first aid in most states, not unless it's part of a job description obviously. Some states will consider it an act of negligence though, if we don't at least call for help. Beyond this, assisting is optional and voluntary, partly due to preserving the rescuer's own health in the process. Without protective equipment the rescuer could be exposed to infectious diseases by coming into contact with a victim's bodily fluids. In short, we are not obligated to render first aid in fear of cross-contamination yet, if we begin to help, we must continue to do so until one of three things happen: the victim recovers, another trained person replaces you or we are too physically exhausted to continue. Stopping for any other reason is interpreted legally as, 'acting unreasonably.' Then the good samaritan laws would offer us no protection if there were a tort suit.

Another doctrine for reference is the emergency doctrine.

'1. A legal principle exempting a person from the ordinary standard of reasonable care if that person acted instinctively to meet a sudden and urgent need for aid-also termed imminent-peril doctrine; sudden-emergency doctrine; sudden-peril doctrine.

2. A legal principle by which consent to medical treatment in a dire situation is inferred when neither the patient nor a responsible party can consent but a reasonable person would do so.'

This law makes a distinct difference between a lay person and a professional performing first aid. 'Exempting a person from the ordinary standard of care', this excludes professionals from being protected by good samaritan laws in wrongdoing. It is specific, again, to a lay person. The second point defines a difference between a conscious and an unconscious victim, 'consent to medical treatment in a dire situation is inferred.' Where an unconscious victim cannot respond, we can help them anyway on the grounds of implied consent. However, if the victim is conscious and can respond, we are to ask their permission to help them first. Otherwise we run the risk of not being protected under either doctrine if we should be sued. These types of suits are known legally as a tort suit, wrongful. No one has been sued successfully in a tort suit since these doctrines were instated, not that a rescuee could not try though.

The consensus among many people now-a-days is, the less we do the better off we are when it comes to helping non-life-threatening emergencies. Thinking of it in these terms is unfortunate for most but, we could look at it this way too. The victim is better served if we place our focus on life-threatening emergencies such as: no breathing, no pulse, severe bleeding and shock. These emergencies could cause death and/or irreversible damage within the time it could take 911 to respond. All other injuries and conditions are non-life-threatening within this period. If we leave these conditions to be treated by the professionals, we won't run as much risk of crossing any legal boundaries. Now, some people may consider this unethical. Nevertheless, the ethical arena is entirely different from the legal arena, isn't it?