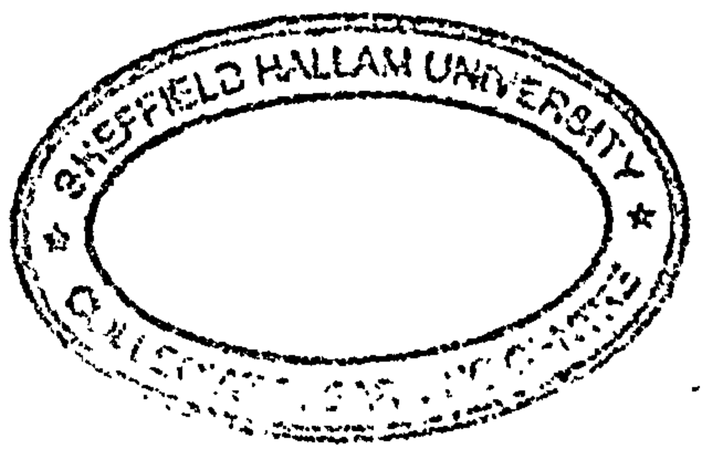
MEDICAL RESCUE, LITIGATION AND COMPENSATION CULTURE: A LEGAL PERSPECTIVE.

KEVIN MAURICE WILLIAMS

Published works submitted in partial fulfilment of the requirements of Sheffield Hallam University for the degree of Doctor of Philosophy on the basis of published work.

October 2007.



PhD by PUBLICATION. CRITICAL APPRAİSAL

Title: Medical rescue, litigation and compensation culture: a legal perspective

Kevin Williams. Reader in Law, Sheffield Hallam University.

1. AIMS of PUBLISHED PAPERS

In *Dorset Yacht Co. Ltd v Home Office* [1970] AC 1004, 1060 Lord Diplock was clear that 'the priest and the Levite would have incurred no civil liability in England'. Whilst the current position is now more complex than appears from this seemingly simple dictum, much of the extensive literature about the law of rescue has traditionally concentrated on (and has not infrequently bemoaned) the absence of any obligation on ordinary passers-by to attempt the 'easy' rescue of needful strangers, despite this alleged lacuna rarely appearing to have presented practical problems. In contrast, the regular and pressing need for rescues to be undertaken by trained emergency workers, such as fire fighters and paramedics, in what may be difficult or dangerous circumstances, such as the aftermath of road accidents, has received comparatively little attention. It is also notable that the attention of most legal commentators has focused on the theoretical and philosophical nature of the law rather than its practical results. One of the aims of the published papers is to redress these historical imbalances by investigating on how far those who are injured or fall ill may expect to benefit, in law and in fact, from professionally provided pre-hospital emergency medical treatment.

A further purpose is to explore what effect the legal rules about rescue have on behaviour, claims, and litigation patterns. In addition to analysing the doctrinal basis of the rules and advocating rationalisation of what are currently inconsistent and uncertain liability regimes, two papers provide some new empirical data. The first (JLS, 2003) concerns the Good Samaritan behaviour of British doctors who emerge as willing altruists, rightly undeterred by fears of being sued by ungrateful rescuees. The second (Med L Rev, 2007) is the first analysis of medical negligence claims against English NHS ambulance services and provides a means of assessing the impact of the important decision in *Kent v Griffiths* [2001] QB 36. *Kent* radically

recognised a duty of professional rescue on ambulance trusts. However, the common law's traditional reluctance to impose duties of affirmative action continues to hold sway as regards other emergency service providers, at least for the present, resulting in what Howarth has characterised as 'the extraordinary rule...that the public rescue services have no duty to rescue anyone'.[1]

The usual formal explanation for these 'no duty' rulings is an absence of 'proximity'. Thus, Lord Nicholls in *Stovin v Wise* [1996] AC 923 at 931 said: 'There must be some additional reason why it is fair and reasonable that one person should be regarded as another's keeper...When this additional reason exists there is said to be sufficient proximity. That is the customary label'. It seems likely that some part of this judicial reluctance to recognise proximity and a duty to rescue is motivated by a concern to avoid burdening the emergency services with widespread and potentially costly liabilities.[2] These potential liabilities are part of a wider debate among senior judges about the circumstances in which public authorities should be made liable to those who suffer damage by the negligent exercise or failure to exercise state powers. According to Markesinis and Fedtke this debate is being conducted by 'restrictive conservatives' on the one hand and 'pragmatic modernisers' on the other.[3] The best that can be said is that, presently, the law here is uncertain and in a state of flux.[4]

Ironically, at much the same time as some claimants were beginning to challenge the conventional 'no duty to rescue' rule, anxieties began to be expressed about the dangers of a so-called 'compensation culture' precipitating a litigation crisis, particularly in certain public services, such as healthcare and education. The political importance of these concerns, the extent to which they represent a real threat to limited budgets financed by taxpayers, and their power to influence a nascent 'tort

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[1] Howarth (2004), at 547.

[2] In *John Munroe (Acrylics) Ltd v London Fire and Civil Defence Authority* [1996] 4 All ER 318 at 332, Rougier J, when rejecting a claim alleging negligent fire fighting for want of proximity, also said it is 'a truism' that 'we live in the age of compensation...Claims that would have been unheard of 30 years ago are now being seriously entertained, and public money provided for pursuing them'. The Court of Appeal was more guarded. They too explained the absence of duty by reference to the Delphic notion of proximity, but rejected as unpersuasive various policy considerations, including floodgates anxieties, so explicitly relied on by Rougier J. See *Capital and Counties plc v Hampshire County Council* [1997] QB 1004, at 1043-4.

[3] Markesinis and Fedtke, at 299.

[4] Of the general question concerning when a public body may be liable in negligence, Bailey and Bowman, at 122, say it is 'increasingly difficult to find a principled basis for the line between liability and non-liability'. See, generally, Booth and Squires. Cf. Harlow.

reform' agenda, is a further strand in the submission. The papers reject as factually unfounded the exaggerated (mainly media-driven) fears that we have become a 'blame and sue' society. The evidence suggests that recognising a duty of medical rescue, in particular, will not result in the NHS facing a litigation crisis.

2. THE RESEARCH PROGRAMME

The work was completed over a seven year period and though not initially planned as an integrated programme the eight publications are driven and informed by a concern about rescue responsibilities. They also trace what connections there might be between the common law's approach to this issue, the practical effects the liability rules have on litigation, and whether these might contribute to the growth of a so-called 'compensation culture'.

The relative absence of evidence concerning the practical effects of liability rules has been the subject of comment across the years. According to Stapleton, 'in general, there is insufficient empirical evidence to conclude whether tort doctrines are influencing public regulation or social norms, such as the behaviour of the target population, either at the pre-tort stage or in how they react to the commission of a tort'.[5] Nonetheless, fears that recognising a new category of duty in negligence may have deleterious consequences is a commonly cited concern of defendants and of some judges.[6] It is a concern that takes different forms: for example, that there will be an indeterminate (or, at least, large) volume of expensive claims; that the threat of liability may discourage the due performance of socially beneficial public services; that potential defendants will resort to excessive risk averse behaviour, such as 'defensive medicine'; or that courts and defendants may find themselves overburdened with vexatious, gold digging or otherwise groundless claims. Craig and Fairgrieve say that such policy concerns seem to 'elude the ordinary rules of evidence' so seldom are they supported by empirical data.[7] Even so, in *Phelps v London Borough of Hillingdon* [2001] 2 AC 619 the House showed a new scepticism and

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[5] Stapleton, at 131. To much the same effect, see Cane, at 649 and the Ipp Report, at 32.
[6] See Rougier J, n 2 above. Lord Hoffmann in *Stovin v Wise* [1996] AC 923, at 958 stressed the 'importance before extending the duty of care owed by public authorities to consider the cost to the community.'
[7] See Craig and Fairgrieve at 636. Cf. Buxton LJ in *Perrett v Collins* [1998] 2 Lloyd's Rep 255, at 277 rejecting as unsupported by 'expert evidence' claims that liability would cause the defendant regulatory body to adopt damaging defensive practices.

reluctance to strike out a novel duty claim on the basis of unproven policy fears, Lord Nicholls pointing out that 'denial of the existence of a cause of action is seldom, if ever, the appropriate response to fear of its abuse'.[8]

It is important to keep in mind that what finishes up in the law reports, the conventional focus of much legal scholarship, may well not be representative either of claims of that type or reflective of the conduct of those involved in the activity. Fulbrook put it this way: 'the cases that are fought, and particularly those that go on appeal, are often on finely balanced points of law, or those that need to be pursued for practical or policy reasons by insurers, and they are therefore rather "special" cases with unique circumstances, and not necessarily likely to re-occur'.[9] Hence the desirability of looking, where possible, beyond the limited range of cases that end up being litigated in the courts to mere claims and their settlement.

Accordingly, a major purpose of four of the papers submitted is to provide some evidence about what is sometimes called 'real world' behaviour outside the highly selective and rarefied atmosphere of appellate decisions.[10] They have involved an opinion and attitude survey of doctors, an assessment of all claims made against NHS ambulance trusts, interviews with representatives of the emergency services, and an evaluation of the significance and reliability of statistical data and other sources of information concerning the compensation culture.[11] Alongside and complementing these fact focused enquiries are analyses of primary and secondary legal sources.[12] These different forms of enquiry, empirical investigation and doctrinal analysis, may be helpful when the future shape and direction of the law falls to be considered.[13]

A list of the publications comprising the submission can be found at the end of the appraisal.

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[8] See too Lord Slynn in *Phelps*, at 655, 'though claims should not be encouraged...the fact that some claims may be without foundation or exaggerated does not mean that valid claims should necessarily be excluded'.
[9] Fulbrook, at 14. See too the editorial comments on the research of Morgan *et al* , at 41 (which concerns the operation of immunity statutes in relation to US ambulance services) pointing to the limitations of any analysis based only on *appellate* hearings. Policy oriented conclusions may be flawed to the extent they are based on a small fraction of the entire national experience of lawsuits or ignore claims that do not go to trial.
[10] See Genn *et al* on the increasing importance of (and the UK's limited capacity to conduct) empirical legal research.
[11] See Williams (JLS 2003), (Med L Rev 2007), (PN, 2003) and (LS 2005) respectively.
[12] See Williams (OJLS 2001), (PN 2003) and (JPIL 2006).
[13] What McCrudden calls, respectively, the 'external' and 'internal' approaches to legal research.

3. ANALYSIS of COMPONENT PUBLICATIONS

3.1. Preliminary outline of the law of rescue in comparative perspective

Unlike many continental European legal systems, common law countries have conventionally refused to recognise a duty to rescue. It appeared that not only were ordinary citizens free to ignore calls for help from needful strangers but so too were healthcare providers and the emergency services. However, two landmark appellate decisions, one Australian, the other English,[14] have laid the foundations of a duty of medical rescue (regardless of the casualty's prior status as a 'patient') and, potentially, of a wider entitlement to rescue by professional emergency services more generally. Presently, however, police, fire, and coastguard services in England (if not in Scotland) are free of any private law obligation to respond to calls for assistance.[15] In that sense it is still true that the common law continues to be less willing to impose duties of protection than it is to remedy harm caused directly by a defendant's own positive acts. Nevertheless, those 'no duty' decisions must now be open to question. At a minimum, *Kent v Griffiths* and *Lowns v Woods*[16] demonstrate that litigation, prompted by egregious failures to provide medical assistance, can be successful, despite apparently well-settled rules denying that tortious liability between strangers is possible.

Paradoxically, those who choose to intervene are theoretically at risk of being sued for negligence by an ungrateful rescuee. Fleming said that the common law had thus 'created the anomaly of subjecting the incompetent Samaritan to liability while excusing the Levite'.[17] Faced with an allegation of this kind, both amateur and professional rescuers in this country must rely for protection on the reluctance of courts to accept that there has been a culpable and causative want of care.[18] The

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[14] See *Lowns v Woods* [1996] Aus. Torts Reports 81-376 and *Kent v Griffiths* [2001] QB 36, respectively.
[15] See the English 'no duty' authorities: *Alexandrou v Oxford* [1993] 4 All ER 328 (police); *Capital and Counties plc v Hampshire County Council* [1997] QB 1004 (fire brigade); *OLL Ltd v Secretary of State for Transport* [1997] 3 All ER 897 (coastguard). In Scotland, the position appears to be otherwise. See *Duff v Highlands and Islands Fire Board* [1995] SLT 1362 (obiter, negligent fire authority not immune from liability) and *Gibson v CC of Strathclyde* [1999] SC 420 (police liable when the task of warning motorists of a partially collapsed road bridge was prematurely abandoned).
[16] See n 14.
[17] See Fleming (1987), at 135.
[18] The fact that a defendant is responding to an emergency may lower the standard of care expected. For a recent example of an emergency rescue, but one not requiring an 'agony of the moment' decision, see *Davis*

further rule that no liability can arise unless defendant volunteers have made an already bad situation 'worse' by some positive act of negligence seems designed to provide them with additional protection. No doubt it is also reflective of the common law's rejection of any *general* duty to make things 'better' initially by embarking on a rescue attempt.

At the level of legal policy, there are a number of other possible responses to the issues surrounding Good Samaritan behaviour or the lack of it. For example, in North America, state and provincial legislators have strongly favoured dangling the carrot of immunity from liability for negligent rescue, apparently hoping thereby to encourage voluntary offers of assistance.[19] In contrast, civilian codes across much of continental Europe mandate rescue, favouring the stick of criminal (and, sometimes, also civil) law sanctions against even private citizens who fail to assist others in nearby need, at least where the putative rescuer would not be exposed to personal danger thereby.[20]

A notable feature of the voluminous literature about the law of rescue is that it is almost exclusively concerned with the philosophical nature and moral suitability of the legal rules as they affect the ordinary citizen bystander.[21] By and large, limited interest has been shown by (academic) lawyers in the actual operation and effect of the rules or how they bear down on other sorts of rescuers, though remarks by some commentators can be found pointing to the seeming absence of 'negligent rescue' suits generally and doctors' exaggerated fears of exposure to liability in particular.[22] Accordingly, it is difficult to say what the pragmatic outcomes of these different strategies have been and which, if any, best achieve the aim of encouraging socially beneficial helping.

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v Stena Line Ltd [2005] EWHC 420 (carrier liable for protracted, negligent attempt to save a ferry passenger who had fallen overboard).

[19] See McInnes (1992a).

[20] See Kortmann, chapter 4, Van Dam, chapter 17, and Smits (passim). What constitutes 'easy' rescue is not without difficulty.

[21] Hyman calculates that in the 50 years to 2000, 162 such articles appeared in US law reviews. For a critique of attempts to utilise 'law and economics' approaches to predict the likely costs and behavioural consequences of different types of rescue laws, see McInnes (1992b). Typically, these too usually concentrate on bystander behaviour, saying little about professional rescuers, apart from maritime salvors.

[22] See, for example, Hurt, at 5.

There are some studies that do provide empirical evidence. The earliest, published in 1973, draws on two surveys of the willingness of doctors in the United States and Canada to provide emergency treatment to strangers. The results were widely different. Thus, whereas only half of US physicians said they would stop and assist at a roadside accident, citing fear of a possible malpractice writ as their principal reason, some 90 per cent of Canadian doctors said they would act as the Good Samaritan did.[23] What explains this marked difference in attitudes was not explored, though a shared Hippocratic Oath and substantially identical systems of medical training seem not to have been particularly influential. Might the differences be attributable, at least in part, to differences in the respective legal systems? There are a number of structural features associated with the US legal system (but which are absent in Canada) that favour plaintiffs and which some see as actively encouraging resort to the law as a primary means of resolving disputes of every sort.[24] In that sense, doctors in the USA might be forgiven for believing themselves to be operating in a legally hostile environment. On the other hand, there is one aspect of the American legal landscape which it might have been supposed would have inclined US doctors to be *more* willing to stop and offer aid, namely, the fact that most American states had by then enacted some form of 'Good Samaritan immunity' to protect physician and other altruistic interveners from being made liable simply for negligent rescue.[25] In contrast, only one Canadian province (Alberta) had done likewise at that point. Gray and Sharpe say that in North America 'successful actions against Good Samaritans occur with about the same frequency as hen's teeth'.[26] Nonetheless, recognising that doctors' fear of litigation and the associated threat to professional reputations was real, even if mistaken, they advocated the adoption of a 'legislative placebo'.[27] Most Canadian jurisdictions have since done so.[28] There is, however, no evidence that granting immunity has been effective, either in the sense that it has encouraged more

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[23] See Gray and Sharpe, at 2.

[24] Among such features are jury trials, contingency fees, punitive damages, and the absence of a 'loser pays' costs rule. See, generally, Burke, and Fleming (1988).

[25] By 1972, 42 US states and the District of Columbia had adopted 'Good Samaritan' statutes. Nowadays all fifty states have them. In recent years, other, more general, pro-defendant tort reforms have been enacted designed to counter a perceived litigation crisis. See Haltom and McCann as to the politics of these reforms.

[26] Gray and Sharpe, at 4. The position does not appear to have changed since, see Schutte.

[27] Gray and Sharpe, at 28.

[28] See McInnes (1992a). Quebec, unusually, has since enacted both a 'duty-to-rescue' rule (sometimes called a 'Bad Samaritan' statute), breach of which may be actionable in damages, *and* a qualified Good Samaritan immunity rule. So too have three states in the USA, see n 41 and text.

North American doctors to render aid willingly or that it was, in fact, initially necessary in order to protect them from a real risk of vexing or vexatious lawsuits.[29]

In 2005, Hyman published an empirical study of rescues by private citizens (rather than by healthcare or emergency services personnel) in the United States. It presents a 'reassuring picture of the behaviour of ordinary Americans', concluding that in practice 'rescue is the rule - even if it is not the law', and that the presence or absence of a legal duty to rescue is unlikely to be a material factor influencing whether rescue occurs.[30] He notes that the number of rescues declined in the first half of the 20th century, but stabilised or increased thereafter. Whether this is related to potential rescuers having been encouraged to act by the immunity held out by Good Samaritan statutes (the first of which was enacted in California in 1959) was unfortunately not pursued, however. Nonetheless, Hyman's evidence contradicts the populist notion that callous disregard for others has become the norm. 'The highly salient anecdotes of non-rescue that everyone knows about are extraordinarily unrepresentative of the real world'.[31]

A third category of empirical work is represented by a number of US studies of claims against Emergency Medical Services (EMS), that is, paramedics and the municipal or private ambulance services for which they work. These studies focus on the type and cost of claims[32] or analyse the nature of the different kinds of legal immunity that may be available to different kinds of EMS defendants.[33]

In the 1970s, two Australian states adopted the North American qualified immunity model. In the event, neither of these legislative provisions has needed to be judicially considered, leading one local commentator to suggest in 1998 that the risk of litigation associated with offering pre-hospital medical help was always likely to be small.[34] My

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[29] See Franklin, at 52. McInnes (1992a), at 240, notes that three Canadian Provinces declined to enact Good Samaritan protection believing that it would be 'otiose'.
[30] See Hyman, at 3, who claims it is 'the first empirical study of the no-duty rule in action' in the USA.
[31] See Hyman, at 4. Perhaps the most infamous 'non-rescue' concerned Kitty Genovese, a young woman who was attacked within sight and earshot of numerous New York neighbours, none of whom raised the alarm during her 30 minute fatal ordeal. The anxieties generated by this widely reported incident prompted the publication in 1966 of a collection of essays, *The Good Samaritan and the Law*, see Ratcliffe.
[32] See Colwell *et al*, and Goldberg *et al.*
[33] See Morgan *et al*,and Wiggins.
[34] See Haberfield, at 63 and 3.2 below.

survey of British doctors in 2003 came to a similar conclusion. British doctors overwhelmingly do help and, so far as is known, not one has been sued.[35] The Ipp Committee, which was appointed by the Australian Federal government in 2002 to recommend changes to the tort system following the collapse of two major liability insurers, declined to recommend that legal immunity be introduced nationally for the benefit of healthcare professionals or others who provide emergency medical assistance voluntarily, notwithstanding that doctors had 'long expressed a sense of anxiety about the possibility of legal liability for negligence'. Such immunity would be 'unnecessary' and 'undesirable'. Unnecessary because there is 'no Australian case in which a Good Samaritan has been sued' and the law would anyway take account both of the emergency nature of the circumstances and of the skills of the particular Samaritan: undesirable because it would 'tip the scales of personal responsibility too heavily in favour of [incompetent] interveners'.[36] This recommendation has been widely ignored, however, and all Australian jurisdictions bar one (Tasmania) have since enacted conditional protections, beginning with New South Wales, the most litigious state.[37] As in Canada and the USA, the Australian Good Samaritan statutes differ as to precisely what kind of protection is available, when, and to whom. Some require that intervention must be undertaken without any expectation of payment or other reward, which appears to exclude professional rescuers, such as fire fighters and paramedics, putting them outside the immunity.[38]

So far as one can judge, the European rules imposing universal 'easy' rescue responsibilities similarly do not seem to be much called into practice, whether in relation to ordinary bystanders or others.[39] Typically, neither do they seem to have

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[35] See Williams (JLS, 2003).

[36] See the Ipp Report, at paras 7.21 to 7.24.

[37] In 2004, the Chief Justice of New South Wales claimed that Australian doctors no longer stop at roadside accidents basing this large assertion on the limited anecdotal evidence supplied by his two brothers, who are doctors, see Spigelman, at 4. In fact, no personal civil liability had attached to Samaritan health care professionals since s. 27 of the Health Care Liability Act 2001 (NSW). This proviso was replaced and expanded by Part 8 of the Civil Liability Act 2002 (NSW) so as to protect *all* those who go to another's assistance.

[38] Queensland, however, protects not only doctors and nurses but designated public safety services, such as the coastguard, fire, and ambulance services. See Stewart and Stuhmcke, at 253-257, and Eburn, for analysis of the differently expressed protections available to medical and other emergency interveners enacted in the post-Ipp era. McInnes (1992a) criticised the ambiguous nature of the messages that the similarly highly various North American statutes send to would-be interveners.

[39] Dedouit *et al*, for example, note the absence of any litigation in France involving doctor-passengers arising out of in-flight medical emergencies. Following the traffic accident in Paris in which Princess Diana died in

been subjected to empirical enquiry. In the absence of evidence we cannot be sure, but it seems inherently improbable that the French or the Germans, say, are more altruistic and public spirited *because* commanded to be so by legal diktat.[40] Hyman tells us that in the three US states which unusually elected to follow the European criminal sanctions approach there have been no prosecutions for non-rescue throughout their combined 80 years of shared experience. Moreover, in these 'duty-to-rescue' states (which have also enacted Good Samaritan immunity) there appear to have been no changes in the number of non-risky rescues (which might have been expected to increase) or in the number of accidental deaths (which might have been expected to decrease). 'Put bluntly', he says, 'the available data provides no indication that imposing a [positive] duty to rescue has any effect whatsoever'.[41]

3.2. Liability Rules and Compensation Culture

Claimants who allege a failure to rescue face a double difficulty. Not only is the common law resistant to recognising damage resulting from omission, but the likely defendants will be one or other of the emergency services, which are public bodies, financed by taxpayers, whose purposes are directed to serving the common good. Because liability in negligence here may involve not just questions of law, but of politics, public expenditure and the allocation of scarce resources, it poses particular problems. 'All judgments against government have financial repercussions'.[42] This has troubled the courts since at least the time of *Home Office v Dorset Yacht Co Ltd* [1970] AC 1004. As Lord Hoffmann observed in *Stovin v Wise* [1996] AC 923 at [13]: 'It is one thing to provide a service at the public expense. It is quite another to require the public to pay compensation when a failure to provide the service has resulted in loss'. Grubb has pointed out that if the NHS is called upon to pay compensation for

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August 1997, no one was prosecuted despite allegations of multiple failures to offer assistance. However, in November 2003, three paparazzi who took photographs at the scene were prosecuted for invasions of privacy.

[40] Gray and Sharpe, at 19, provide some examples of prosecutions in France but conclude there is no 'very convincing' evidence about the law's effect on behaviour. The comparative lawyer, Tunc, at 43, while observing that 'a change in men's hearts cannot be ordered by legislation', praised French law for bringing law and ethics closer together.

[41] Hyman, at 39. For a critique of such 'Bad Samaritan' statutes in the USA, see Dressler. Their seeming lack of use, whether in Europe or in parts of North America, is under-researched and thus is largely unexplained by empirical evidence. As regards the USA, Hyman suggests 'most likely there never were any actionable non-rescues...to begin with'.

[42] King, at 196. See too Poole, at 257, noting that sceptics, such as John Griffiths, regard much 'rights talk' as being essentially concerned with issues of politics, economics and the distribution of power dressed up as questions of law.

negligent medical rescue, this may be portrayed 'as diverting precious financial resources from the treatment and care of patients' (as if such claimants are somehow necessarily undeserving and not themselves damaged patients), as well as being likely to set 'political alarm bells ringing'.[43] McIvor says that 'in our increasingly litigious society...the perceived "deep pockets" status of public authorities will make them vulnerable targets for wily claimants'.[44]

Whether society is 'increasingly litigious' and whether claimants and their lawyers are increasingly acting strategically so as to target limited public budgets are important and highly contentious questions, the answers to which are in principle amenable to empirical investigation, rather than being propositions to be simply asserted.[45] In the past, when answers have been offered, typically they have tended to rely on anecdotal evidence or have reflected political (though not necessarily party political) positions; some have amounted to little more than media-driven speculative scare stories.

The three final papers listed in this submission attempt to assess how far such fears are in fact well founded, both generally and as regards medical negligence claims against the NHS.

3.3. Review of the Published Papers

3.3.1. Medical Rescue and Pre-hospital Emergency Treatment

Essentially, the first four publications examine two aspects of 'medical rescue', namely, how far English law imposes a legal duty to provide assistance and what actually happens in practice.

The first article (OJLS, 2001) is a theoretical and doctrinal analysis which argues that healthcare professionals *should* be obliged by law to provide treatment to those in

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[43] See AG, at 350.
[44] See McIvor, at 99.
[45] Of course, data may be unavailable or limited. For example, Morris, at 359, points out that the figures from the Compensation Recovery Unit, while useful, shed little light on the extent to which claims against schools and local authorities have increased in recent years.

immediate and nearby need, notwithstanding that the casualty has no prior status as a 'patient' of the practitioner in question. The orthodox objections to affirmative obligations are shown to be unconvincing in this context. Recognising a positive duty of beneficence will align the law with moral sentiment, professional ethics, public expectation and respect for human rights. However, the purpose of imposing liability to pay damages for loss resulting from so-called 'bad Samaritan' behaviour should not be to promote altruism as such, seemingly the main aim behind the North American and continental European legal strategies. As the next paper shows (JLS, 2003), probably no such encouragement is necessary. The purpose should rather be to provide compensation in accordance with standard notions of corrective justice in those rare cases where a casualty has been harmed unnecessarily by egregious negligence when they might readily have been saved. It is, of course, beyond the power of the law to make people good.[46] However, it is not uncommon for the law to condemn in damages those who culpably fail to come up to community standards of expected behaviour.

The second article (JLS, 2003) reports the results of the first survey of British doctors' experiences of, and attitudes towards, providing emergency treatment outside the confines of a surgery or hospital.[47] Regardless of what the law may say, and contrary to a belief in some quarters that modern doctors are reluctant to act as Good Samaritans, overwhelmingly they emerge as willing altruists. Almost three quarters of respondents said they had provided treatment to a stranger in the past and an even larger proportion claimed they would help should the need arise. Media-fuelled claims about deteriorating standards of social responsibility and the alleged onset of a 'walk-on-by' society are shown to be out of place in this context. A strong internalised moral and professional sense of obligation was the principal force motivating those who participated in the study. The external obligation in the General Medical Council's code of professional ethics mandating assistance under pain of disciplinary sanction appeared to be only poorly understood and, consequently, must frequently have been honoured in ignorance.

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[46] Cf. Rudzinski, at 122, characterising as 'stale' and a 'half truth' the argument that it is impossible to 'legislate for morality'.

[47] I am grateful to the Human Rights Research Centre for funding this research.

Nor, apparently, is the threat of potential liability should things go badly a deterrent to doctors offering help. The survey uncovered little evidence of self-regarding attitudes or conduct that might be characterised as excessively cautious or 'defensive'. The actual or predicted Samaritan behaviour of doctors seems to be largely unaffected by their knowledge of the law (which is patchy) or by fear of legal liability. Despite some doctors expressing anxiety about 'ambulance-chasing' lawyers, the majority do not feel the need of any special legal protection, such as operates in North America.[48] That intuition is sound. Providing emergency care as a Samaritan is extremely unlikely to result in a claim, much less liability. The research was unable to identify a single instance where a British doctor had faced such a claim.[49] It is, anyway, a mistake to believe that malpractice suits are more likely to arise out of pre-hospital medical rescues, which are comparatively rare events, than from the day-to-day treatment encounters between doctors and their own patients, in relation to which, of course, no special legal protection is available. Nonetheless, more could helpfully be done by the medical press and the defence societies, as well as by the system of medical education and training, to reassure doctors that the risks of being sued are extremely remote and that insurance cover is ordinarily available to them as part of the standard indemnity package should it ever be needed. Currently, the NHS regards the provision of Good Samaritan treatment by hospital doctors as being outside their terms of service and, hence, somewhat mean-spiritedly, as also being outside the protection offered by the NHS (Crown) Indemnity scheme.[50]

These findings have implications for the future direction the law might take. In *Capital and Counties plc v Hampshire County Council* [1997] QB 1004 at 1035, Stuart-Smith LJ said, obiter, that doctors who stop at roadside accidents do not put themselves into a doctor-patient relationship with the casualties they treat and, thus, they can only be liable, if at all, should they make matters 'worse'. If the unspoken

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[48] Thirty years ago, a majority of Canadian doctors said they wanted US-style Good Samaritan immunity. As Gray and Sharpe observe, at 25, this was perhaps surprising given that nine out of ten Canadian doctors also said that they would be prepared to stop and assist a roadside casualty.

[49] Cf. Griffiths, commenting on an unsuccessful attempt in 1988 to make a volunteer member of St John's Ambulance liable for giving first aid alleged to have been negligent.

[50] See NHS Executive, *HSG (96)48*. In contrast, GPs are legally obliged by statutory regulations to provide emergency treatment to anyone in their practice area, though being independent practitioners they too are outside the scheme. Some ambulance trusts include an additional term in the employment contracts of paramedics requiring them to provide emergency Good Samaritan assistance when off-duty. Presumably, such acts attract NHS Indemnity because contractual. Charitable volunteers and students working under NHS staff supervision are covered by Crown Indemnity. There is scope here for rationalisation.

rationale behind this (legally doubtful) dictum is a perception that it is necessary in order to promote Good Samaritanism or to reassure fearful interveners about the risk of having to pay damages, the evidence provided by the Sheffield survey shows that such concerns have little or no basis in fact.

The third article (PN, 2003) analyses the work of the police, fire, and ambulance services when called on to deal with the aftermath of road traffic accidents. Every year some 3,500 people are killed and more than 300,000 are reported as injured.[51] Traffic accidents, rather than fires, have become the core business of fire brigades in modern times, as legislation now somewhat belatedly recognises.[52] In practice, all three services operate common protocols, mount joint training sessions, and must act in highly integrated and cooperative ways if they are to be effective in saving persons and property.[53] Yet they are currently subjected to two different liability regimes, which is productive of incoherence at the level of legal theory and confusion at the practical level. Tort law currently sees such rescues as a series of highly segmented processes. Police and fire fighters providing first aid or cutting trapped motorists from vehicles are performing tasks that are, in private law terms, apparently discretionary.[54] Their failure to attend or late arrival cannot be challenged as actionable negligence, and however incompetently they deal with the situation once at the scene are free of liability unless by some positive act they add to the harm the victims would have suffered had they done nothing whatsoever. The attendance and work of ambulance crews, on the other hand, is obligatory. They can be called to account for the timeliness of their arrival, as well as for any unreasonable failure to provide beneficial treatment that would probably have made the casualties better, and not simply for having made them worse.[55] The result is that the gap between law and practice is now so wide as to confound the reasonable expectations of the public

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[51] The true figure is likely to be higher since not all RTA injuries are notified to the police, see the analysis by the Road Research Laboratory.

[52] See now the Fire and Rescue Services Act 2004, s. 8, declaring that fire and rescue authorities 'must make provision' for rescuing and protecting people in the event of a road traffic accident. Previously, the Fire Services Act 1947 had classed this work as a 'special service', as if it were simply an optional extra.

[53] Additionally, in the future, all rescue services may operate from common regional control centres.

[54] See the 'no duty' cases cited in n 15. The government's aspiration to have all rescue services undertake 'co-responding duties' has an industrial relations dimension. In *Nottinghamshire and City of Nottingham Fire and Rescue Authority v Fire Brigades Union* [2007] EWCA Civ 240, the Court of Appeal confirmed that presently fire fighters are not *contractually* obliged to administer first aid or other medical interventions at the scenes of emergencies where ambulance crews cannot attend in time.

[55] See *Kent v Griffiths*, n 14.

and, probably, of the various rescue services also. As Howarth observed in a different context, 'state services suddenly manifested themselves not as entitlements but as a kind of undeserved gift. We were told that we had no legitimate expectation to benefit from them and if we did benefit, we were simply lucky'.[56]

The paper traces how we found ourselves in this unsatisfactory state of affairs. The courts hearing the fire brigade cases extended the broad (if qualified) 'immunity' granted to the police in the context of fighting crime to the very different context of emergency and rescue crews fighting fires. The paper argues that the courts were much too eager to ignore the very different context and functions of the police when investigating crime, too ready to make dubious factual and analogical assumptions, and too influenced by unproven floodgate anxieties. It might be possible to argue that the 'no duty' rulings in favour of brigades when called to fires do not extend so far as to cover calls to attend traffic accidents, though it seems highly unlikely that mounting a technical assault of this sort on the ratio would be successful. In this way, English law became the uncritical victim of 'immunity creep'.

Delays by ambulance personnel in the provision of pre-hospital emergency care have been a source of public concern, official investigations, and litigation. In 2000, the Court of Appeal confirmed that an ambulance trust could be liable in negligence where unreasonably late arrival results in damage to a casualty.[57] The fourth paper (Med L Rev, 2007) provides a detailed analysis of this apparently radical liability rule, arguing that it should be broadly read.[58] It also assesses *Kent's* contribution to the litigation profile of the NHS by providing the only detailed analysis of the types, outcomes and costs of all compensation claims made against English ambulance trusts across a ten-year period. The paper demonstrates that recognising a duty on ambulances to provide timely pre-hospital care has resulted in few claims. Less than one claim in five of the total of 263 claims involved any allegation of delay and, of these, more than 80 per cent failed. So far, at least, *Kent* has not produced the intolerable flood of impossible-to-defend and expensive litigation predicted by the

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[56] See Howarth (2001), at 578.
[57] See *Kent v Griffiths*, n 14.
[58] There is some inevitable overlap between the first four papers as regards accounts of how far *Kent v Griffiths* and *Lowns v Woods* have contributed to the development of the law of medical rescue. See OJLS pp 401-403, JLS pp 271-276, PN pp 523-524, and Med L Rev pp 154-161.

NHS Litigation Authority and some commentators. Nor has there been any step-change in claiming behaviour, in the litigation propensities of those casualties who believe that they were dealt with inadequately, or in the settlement of claims. These outcomes are, perhaps, rather as the Court of Appeal had hoped, albeit that at the time *Kent* was decided the Court was inevitably acting in an empirical vacuum. The surprisingly small ten-year total of 263 claims against ambulance trusts identified by the study represent 0.86 per cent by number and 0.54 per cent by value of all the medical negligence claims made in the period against the NHS as a whole. Overall, fewer than three claims in ten succeed and compensation payments appear to be relatively modest. Conventional complaints about simple care failures when transporting patients or treatment errors are four times more likely to be brought than allegations of unreasonable delay or failure to rescue. Claims of the latter sort are, moreover, less likely to succeed than claims of the former sort.

The fifth submission (MLR, 2006) is an invited review of a monograph concerning the general law of rescue and the extent to which European legal systems, based on the Roman law idea of *negotiorum gestio*, allow rescuers a remedy where necessitous intervention results in costs to them. In line with much traditional legal scholarship, it focuses on whether the common law should adopt a rule mandating bystander rescue. Kortmann advocates a combined 'sticks' and 'carrots' approach: ordinary citizens newly compelled to attempt easy rescue but protected from consequential losses by rules designed to make rescue largely cost-neutral for them. Whatever its other undoubted merits, this approach is ultimately disappointing. No empirical evidence is offered to explain why or indeed whether justification exists to make universal altruism compulsory. Moreover, not only does it fail to distinguish volunteer from professional rescuers but it also fails to recognise that the real and pressing problems are unlikely to concern timorous bystanders whose resolve needs only to be stiffened by the threat of legal sanction. It is much more likely that public agencies of one sort and another, including for example child protection authorities, will be the ones to find themselves cast in the role of failed (professional) rescuer.

3.3.2. Compensation Culture

The remaining three publications consider aspects of the so-called 'compensation culture'.

LS 2005 was the first published academic assessment of the evidence said to support the then newly emerging concerns in government, the media and elsewhere that a developing compensation culture was precipitating a litigation crisis in this country.[59] It was cited with approval by Ward LJ in *Corr v IBC Vehicles Ltd* [2006] ECWCA Civ 331 at [63].

'Compensation culture' is a loaded term implying an increased and unreasonable willingness to seek legal redress when things go wrong, whilst 'litigation crisis' implies that this shift in social attitudes has been translated into undesirable (perhaps unbearable) levels of formal disputing. The incidence of personal injury claims has been the locus of most disquiet, though a highly diverse range of claims feature as part of the 'problem' in some accounts. The paper confirmed that certain sorts of accident claims have risen (from a relatively low base) but that there has been no significant growth in the number of claims in recent years.[60] The *cost* of claims has risen, however, principally because of judicial and statutory changes in the way that damages payments are calculated.

In 2004, the Better Regulation Task Force had concluded that the 'real' problem was not so much the number of actual claims as the apparently widespread acceptance of a mainly media-driven 'urban myth' about our increased propensity to 'blame and claim'. This was said to have caused some (particularly, perhaps, public sector) organisations to believe that they were at heightened risk of being sued unfairly. The Task Force's two further conclusions that the myth had somehow provoked an increased (albeit undefined) proportion of the public to 'have-a-go' by making speculative or spurious claims, which in turn had generated an excessively risk-averse

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[59] See also the later studies by Lewis *et al* (2006), Mullender (2006), and Morris (2007).
[60] The statistical analysis of Lewis *et al* confirms that whilst the incidence of personal injury claims has increased almost threefold since the time of the Pearson Royal Commission in the early 1970s (more than half the overall increase being attributable to claims arising out of road accidents), there has been no significant shorter term increase: across the last decade, the number of injury claims has remained stable and may have fallen.

culture amongst some potential defendants, were criticised as lacking systematic analysis and evidential support.[61] Subsequently, the House of Lords Select Committee on Economic Affairs in June 2006 said that 'we have been unable to find any significant evidence...that Britain has become an increasingly risk-averse society' or that it had fallen victim to a compensation culture.[62] Overall, the British continue to be 'lumpers' rather than litigators.

Long before the recent compensation culture debate began, the medical profession appeared unduly prone to exaggerating its exposure to (unfair) litigation. 'Defensive medicine', on one view a form of risk-averse behaviour, was commonly cited by the profession (and by some judges) as an undesirable, albeit perhaps understandable, response to the growth in medical negligence claims. Both defensive medicine and compensation culture are highly contested phenomena, of course. Moreover, whilst the number of claims against the NHS has undoubtedly increased significantly over the last thirty years, it is also the fact, too little commented upon, that only one in fifty, maybe as few as one in a hundred, patients damaged by what appears to be medical negligence makes a claim.[63] The idea that the NHS is disproportionately a target for opportunistic litigants is part of the 'myth'.

In 2006, drawing partly on material in LS 2005, written evidence was submitted to the House of Commons Constitutional Affairs Committee inquiry into compensation culture denying that we are in the grip of litigation crisis.[64] The submission also commented on what was then clause 1 of the Compensation Bill, characterising it as

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[61] Cf. Morris who, at 350, claims that false perceptions about our propensity to claim 'have encouraged excessive risk aversion and a sub-culture of spurious claims', only later to say, at 361, that the evidence of spurious claims is 'simply anecdotal' and, at 367, that the extent of the problem of risk-averse behaviour 'is unclear'. In 2006, the Better Regulation Commission argued for a more considered legislative response to risk. The dangers of regulatory overkill are currently being scrutinised by a cross-departmental ministerial working group. Government hopes that controlling 'claims farmers' via Part 2 of the Compensation Act 2006 will minimise the likelihood of spurious claims.

[62] See HL Paper No. 183-I, at para 32, also expressing scepticism 'about whether general risk aversion can be [meaningfully] measured'. A study of the extent of disproportionate risk aversion was promised by the HSE in 2005, though no report has yet been published.

[63] See *Making Amends*, and Pleasence, respectively. Medical negligence claims against the NHS (which constitute about 1.5% of all personal injury claims) appear to have peaked and may be declining, albeit erratically, see Jones. In total, the cost of medical negligence claims is less than 1% of the overall budget of the NHS.

[64] See HC 754-II, Evidence 183.

'an unnecessary solution to a non-existent problem'.[65] The Committee's main conclusions were: that Britain was 'not moving towards a "compensation culture" driven by a significant increase in litigation'; that while press stories about 'compensation and risk aversion may give a distorted impression' they may still have a 'significant effect' on the behaviour of potential defendants; and that whilst the proposed regulation of 'claims farmers' was to be welcomed, 'the attempted statutory restatement of the common law' in clause 1 of the Bill was unlikely to have 'any useful effect'.[66]

It is not hard to find media accounts of seemingly frivolous claims or apparently disproportionate risk-averse behaviour, though frequently they may well not be representative and some are simply untrue. An example of the latter sort is highlighted in the final publication listed in the submission (JPIL, 2006). It illustrates how a completely spurious, though oft repeated, media-generated compensation culture story (the 'Hanging Baskets of Bury') influenced government and helped shape the legislative agenda. The paper traces the media and other influences leading to the enactment of section 1 of the Compensation Act 2006. The section purports to provide a partial re-definition of fault for the purposes of a negligence action by allowing a court, when deciding whether there has been a breach of duty, to consider whether imposing liability might prevent or discourage a 'desirable activity'. Whether this will have more than a negligible impact on the outcome of (personal injury) claims is highly doubtful since the section arguably merely restates the existing common law, though the possibility of satellite litigation attempting to secure a more defendant-friendly understanding of the currently undefined notion of 'desirable activity' cannot be discounted. It is, however, unlikely that ambulance trusts or other healthcare providers will find it easier to defend claims.[67]

Whatever the section's ultimate legal effect, seemingly it has a number of immediate propaganda purposes. These include helping to counter the misapprehension, said to

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[65] Howarth (2006), at 456, suggests that lack of public understanding of negligence is a 'serious problem' in itself, as well as being 'a source of pressure for not necessarily beneficial change' to the law.
[66] See HC 754-I, at paras 111-114.
[67] Of greater utility may be s.2, Compensation Act 2006, which declares that an apology or offer of treatment or other redress shall not 'of itself' amount to an admission of liability. This is consistent with and may help to promote the declared NHS goals of speedier settlements and greater openness following an adverse event, aims shared with the NHS Redress Act 2006.

afflict some potential defendants, that liability follows simply from the fact of injury, as well as encouraging them to become less risk-averse and to adopt more robust responses to dubious claims.[68] Allegedly, perception can be at least as important as reality and has become a suitable subject for legislation. Yet whether anyone's behaviour will be materially changed by how the negligence formula is expressed in a statute may be doubted: socially beneficial helping will almost certainly not increase nor claim numbers reduce because of it.

Section 1 is a low level tort reform measure, a placebo, which is expected to have few practical consequences.[69] The same may not be true of the NHS Redress Act 2006, on the other hand. It seems probable that substantially more claims (albeit of relatively low value and capped at £20,000) will be lodged in the future given that claiming compensation is to be made easier by a redress scheme that is intended to provide damaged patients with an alternative to issuing court proceedings.[70] Institutional structures of this sort are likely to have a much greater influence on claim numbers than alleged changes in the litigious propensities or the private motivations of opportunistic patients.

4. SYNTHESIS

From a policy perspective and the development of legal doctrine, the incidence of medical rescue and of associated claims or litigation matter because they help to indicate which problems, if any, may appropriately be solved by legal mechanisms. Thus, whilst the infrequency of non-rescue in the USA may not be dispositive of the question whether state legislatures ought to alter their laws so as to oblige bystanders to rescue strangers, Hyman argues that this fact should feature in any discussion about whether reform should be attempted since it 'profoundly affects the costs and

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[68] See Government Response to the Constitutional Affairs Committee's Reports, at paras 39-49.
[69] Cf. the recent and extensive tort reforms in Australia, which have resulted in a 'substantial decline' in litigation rates. The reforms were predicated on the basis of an insurance and litigation crisis. Subsequent analysis strongly suggests that there had, in fact, been no significant increase in personal injury litigation leading up to the Ipp review and hence no empirical foundation for the consequent legislation, see Wright.
[70] The Health Minister, Jane Kennedy MP, told the Constitutional Affairs Committee in March 2006 that the projected increase in medical negligence claims was expected to range from 2,200 to 19,500 a year. The Government's Response to the Committee's Reports estimates the costs of the scheme in its first year at between £48m and a net saving of £7m.

benefits' of any such exercise.[71] Similarly, in this country; if, for example, it could be shown that (fear of) litigation materially inhibits the provision of Good Samaritan emergency medical treatment that would be much more socially significant than the absence of any legal duty on passers-by to go to the aid of toddlers drowning in shallow pools. Fortunately, the evidence is that doctors in Britain overwhelmingly do act as Good Samaritans and that altruism is a core value in practice and not just a matter of ethical theory. Moreover, doctors are not sued as a result of their interventions. Allegations that standards of professional responsibility have declined due to or at least hastened by a 'blame and sue' culture are wide of the mark.

English ambulance services, which every year make more than three million 'emergency patient journeys', face claims in only a minute percentage of cases, most of which concern allegations of conventional care and treatment failures rather than complaints about the timeliness or the fact of rescue.

The other emergency services are currently free to ignore calls for help, of course. The justifications for a 'no duty' stance in these cases vary but include the act/omission distinction and the potential of positive obligations to infringe individual liberty, though unlike private citizens, public bodies generally, and the emergency services in particular, are not indifferent onlookers in the face of urgent medical need.[72] Moreover, the distinction between acts and mere omissions is not always treated as the critical issue.[73] Depending on the precise context, judicial attention may focus instead on a variety of other concerns, such as the possibility of indeterminate (or, at least, burdensome) liability, the unproductive diversion of scarce resources, the risk of a fearful collapse of morale or a retreat into defensive practices which may distort priorities and hinder the efficient delivery of beneficial public services.

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[71] See Hyman, at 2. Of course, some (criminal) conduct, such as bigamy and blackmail, is regulated regardless of its frequency.

[72] See dicta of Lord Nicholls and Lord Hoffmann in *Stovin v Wise* [1996] AC 923, at 935 and 946.

[73] Booth and Squires, at para 3.109, note that some cases adopt a 'proximity' analysis while others approach what is essentially the same issue of principle via 'omission'. In *X (Minors) v Bedfordshire CC* [1995] 2 AC 633 the act/omission distinction did not feature, whereas its importance was emphasised strongly in *Stovin v Wise* [1996] AC 923. *Kent v Griffiths* [2001] QB 36 considered both.

The resulting liability regime looks haphazard and illogical. However, this may not be too surprising in an era when exaggerated compensation culture anxieties have entered the mainstream of public discourse and have even resulted in a partial statutory restatement of the notion of fault in negligence.[74] Given this context, judicial reluctance to recognise a general responsibility of professional rescue for fear, inter alia, of visiting unpredictable financial calamity onto the public purse is understandable, if arguably misplaced.

5. CONTRIBUTION to KNOWLEDGE

Rather than devote any more philosophical attention to the question whether ordinary citizens should be obliged to attempt easy rescue, the answer to which it is submitted should continue to be 'no', we would be better employed assessing the desirability of imposing a duty of professional rescue for the benefit of those at physical risk. In line with human rights jurisprudence,[75] the basic building blocks for constructing a theory of liability are already available, though we should be careful not to underestimate the extent to which English courts are likely to continue to be cautious about imposing liability on public authorities or to depart from the orthodox position that there is *normally* no duty of care to confer benefits on another.[76] Nonetheless, it is suggested that such a duty should be held to exist whenever a relevant authority knows or reasonably ought to know that vulnerable, identified or identifiable persons are at real and immediate risk of serious physical harm, injury or illness.[77] What matters is the urgent need of the victim, so that it ought to be irrelevant whether the need results from their own behaviour, natural processes or the acts of others.

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[74] See s.1 Compensation Act 2006 and JPIL (2006).

[75] The influence of human rights on the development of domestic affirmative duties is beginning slowly to be felt, and is likely to increase. See, for example, *Van Colle v Chief Constable of Hertfordshire* [2007] EWCA Civ 325 (having ignored an escalating pattern of intimidation, the failure of the police to protect a witness in a criminal trial from a fatal attack by the accused breached Art 2, ECHR. The claim did not allege common law negligence.). Hickman discusses how negligence and human rights principles might be best aligned.

[76] See, generally, Booth and Squires. Van Dam, at 467, notes that 'all [European] legal systems are very reluctant in accepting liability for pure omissions, particularly in rescue cases'.

[77] 'Relevant authority' means here police, fire and rescue, and the coastguard services. The position of voluntary, non-state actors, such as Mountain Rescue teams and the RNLI, which are not funded by taxpayers but largely by charitable donations, requires separate and careful consideration.

It is suggested that the focus of judicial attention ought then to shift from duty to the utility of breach as the principal gatekeeper of liability.[78] At that point no doubt courts considering whether the duty to rescue has been met will be particularly sensitive to the nature of the emergency, the risks it presents to the rescuers, their professed skills and operational choices, and any constraints which competing priorities and limited time or resources impose. The burden imposed on defendants should not be disproportionate and claimants should be expected to prove breach with convincing clarity. The *Bolam* standard, as interpreted in *Bolitho*, imposes a properly demanding test of fault without the need to introduce a concept of 'gross' or 'subjective' negligence, which would be unhelpful and fragmenting refinements.[79] Moreover, as Lord Bingham reminded us in *JD v East Berkshire Community Health NHS Trust* [2005] UKHL 23 at [32], 'the professional is not required to be right', merely careful.

In the past, too little (academic) attention has been paid to gauging the position of publicly funded professional rescuers. It is also true, as noted earlier, that studies of the practical aftermath of liability decisions generally remain comparatively rare.[80] Yet, as Lord Steyn observed in *Eastwood v Magnox Electric plc* [2004] UKHL 35 at [39]: 'the way in which a rule or principle operates in the real world is one of the surest tests of its soundness'. What has largely been missing until now is some indication of the likely effects of adopting such a theory of liability. This is not without its difficulties and uncertainties, of course. Nonetheless, the empirical data provided here concerning medical rescue suggest that the consequentialist fears expressed by some judges and commentators have so far proved to be unfounded.[81] Moreover, the research has also shown that we should be careful before we too readily accede to generalised and largely unsubstantiated claims that the legal system

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[78] Dicta in *Phelps v Hillingdon London Borough* [2001] 2 AC 619 and elsewhere support this approach. See too Bailey and Bowman, at 131-132, and Craig and Fairgrieve, at 638-639.

[79] See *Bolam v Friern HMC* [1957] 1 WLR 582 and *Bolitho v City and Hackney HA* [1998] AC 232. In addition to establishing breach, proof of causation and damage may be expected to be significant sources of difficulty for some claimants, as in *Bolitho* itself.

[80] Much the same appears to be true elsewhere. Cane, at 649, writing in Australia, notes that evidence about the regulatory impact of tort liability is 'largely speculative'. The American scholar, Professor Maurice Rosenberg, cited in Hyman, at 46, once asked: 'Why are lawyers uninterested in facts? The tendency of legally-trained minds to prefer thinking to counting is legendary'. Cf. the ground-breaking work of Dewees *et al* in North America, and the study by Markesinis and Fedtke of the practical outcomes of public authority negligence liability rules in Germany.

[81] The National Audit Office in 2005 observed that complaints and litigation have tended to be an 'under-exploited...learning resource within the NHS', see NAO report, at 10.

already faces a personal injury litigation crisis to which an extension of liability of the sort advocated here will further and damagingly contribute, much less that compensation rights should be curtailed.[82]

Doctors are willing Samaritans, regardless of what is said by the common law or the GMC's code of professional ethics. Contrary to some collegially circulated stories, they do not face lawsuits from those they help, and most doctors rightly have no strong wish to see special immunity rules introduced for their benefit either.[83] It is not without significance that the standard indemnity packages underwritten by the two major medical defence organisations nowadays provide automatic protection at no extra cost.

The theoretically radical imposition of a duty on ambulance services to respond reasonably promptly has resulted in few claims, poor success rates and low payouts, contrary to some fearful predictions.[84] It cannot plausibly be said that the NHS faces a litigation crisis in this particular respect or, indeed, generally.[85]

The evidence suggests that providing doctors and other medical rescuers in Britain with special protection (as happens in North America) or mandating assistance (as in parts of mainland Europe) is neither desirable nor necessary, whether in order to encourage rescue, mollify exaggerated fears of liability, punish failure, or to immunise incompetent rescuers from potential claims. However, the common law *should* recognise the existence of a legal duty to provide emergency treatment in order that the rare victims of truly egregious failures are justly compensated.

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[82] See n 69 on the importance of basing tort reforms on a sound evidential base.
[83] See JLS, 2003.
[84] See Med L Rev, 2007.
[85] See n 63 and text, and LS, 2005.

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