

**LEGAL LIABILITIES FOR ASSISTANCE AND LACK OF ASSISTANCE  
RENDERED BY GOOD SAMARITANS AND VOLUNTEERS**

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## INTRODUCTION

Although no legal action against a first-aider or 'Good Samaritan' or volunteer has ever been instigated in Australia, the fear of the possibility persists in the public mind.

It is no better illustrated than an episode in October 2003 on a popular television programme '*All Saints*' and the subsequent subject in *The Courier Mail* from which the following is an excerpt:

It seems that (in) a couple of *All Saints* ago, ward nurse Von Ryan was sued successfully by the unforgiving family of a woman whose life she had failed to save. Poor nurse Von, and poor people who believe what they see on TV, because this particular event does not reflect reality. The viewing public took Von's predicament to heart and resolve grew that Von's legal troubles could morph out of the TV and be visited upon them... Talkback radio ran hot. Citizens threatened to pull out of first aid courses and voluntary jobs. Despite popular opinion ... first-aid agencies such as Red Cross and St John's Ambulance say that there has never been a case of a person being sued for giving first aid ... But St John's is worried that the fictitious threat will cause people to stop enrolling in first aid courses for fear that by putting into practice what they learn could land them in the dock. 'It would be a tragic day when Queenslanders stop enrolling in courses because of fear of legal action' St John's Queensland chief executive officer Errol Carey says. "First aiders are protected under the Law Reform act 1995. If you go to the aid of someone and help them up to the level of training you have received, you are protected

<sup>1</sup>.

The motto of the Australian Resuscitation Council encourages rescue:

Any attempt at resuscitation is better than no attempt <sup>2</sup>.

This is indeed laudable but to what extent should a "duty to rescue" be imposed, and if so imposed, what standard of care should be expected?

This paper examines common law and legislation related to these issues as it pertains to Good Samaritans and volunteers, not only as a consequence of their actions, but also as a consequence of their inaction. It seeks to determine if they have a duty to rescue, and if undertaking rescue, what are their liabilities.

## A) IS THERE A DUTY TO RESCUE?

### 1. COMMON LAW, (*Lowns v Woods*)

The decision in case of *Lowns v Woods* <sup>3</sup> radically changed the relationship between medical personnel and persons requesting assistance, even though unknown to each other, based on a tort of negligence. Hitherto, there had been no requirement in law for a doctor to render assistance to an unknown person. It has implications for other persons holding themselves out as having special skills.

The case involved an 11-yr-old boy, Patrick Woods, who had been long subject to epileptic convulsions but who at approximately 9 am in January 1987 had been left at the apartment where the family was holidaying while his 14-yr-old sister Joanne was asleep and his mother absent while out walking. Upon returning, his mother

discovered Patrick in *status epilepticus*, and sent his 18-yr-old brother Harry to fetch an ambulance and his 14-yr-old sister Joanna to fetch a doctor. His sister, ran approximately 300 metres to the nearby surgery of Dr Lowns and requested him to come to the apartment and give assistance. On hearing that an ambulance had been or was being requested, he refused. (Dr Lowns denied that he had been so requested but, significantly, the court held that Joanna's request had indeed occurred). In the meantime, Harry had managed to summon an ambulance, staffed by 2 ambulance officers, from a station situated adjacent to Dr Lown's surgery and accompanied them back to the apartment, waving to his sister as the ambulance approached the apartment and she on her way to Dr Lown's surgery. The ambulance officers were not able to give any treatment to terminate Patrick's convulsion and so conveyed him to a nearby general medical practice staffed by three physicians other than by Dr Lowns. They too were unable to terminate Patrick's convulsion and he was subsequently transported to Gosford Hospital where control of convulsions was finally achieved. However, prolonged hypoxaemia had been present and Patrick sustained major brain damage and permanently disabled with quadriplegia. The plaintiff sued on the basis of legislation, contract and negligence.

### **i) *Medical Practitioners Act 1938 (NSW)***

The plaintiff sued on the basis that there existed a statutory duty to assist based on the existence of s 2(1)(h) of the *Medical Practitioners Act 1938 (NSW)*. The Act had been recently amended in June 1987 to include refusal to attend as professional misconduct.

The Act (27)(h) specifies as professional misconduct:

Refusing or failing, without reasonable cause, to attend, within a reasonable time after being requested to do so, on a person for the purpose of rendering professional services in the capacity of a registered medical practitioner in any case where the practitioner has reasonable cause to believe that the person is in need of urgent attention by a registered medical practitioner.

The action against medical practitioners guilty of professional misconduct was referral to the Medical Board (32B) which was able to suspend the registration of a medical practitioner (a) or impose restricted conditions of practice (b). The practitioner could appeal to Medical Tribunal and a Professional Standards Committee or of the New South Wales Medical Board.

However, since there was no provision for civil action against a medical practitioner contravening the Act, breach of the Act was abandoned a the basis of action against Dr Lowns. However, the principles espoused in the Act were to be used in part as a breach of a duty of care.

### **ii) Doctor-patient relationship**

The plaintiff also pleaded that the conversation between his sister Joanna and Doctor Lowns constituted establishment of a doctor-patient relationship (contract). However, the trial judge, Badgery-Parker J, disallowed that as sufficient creation of a doctor-patient relationship.

### **iii) Breach of duty**

The principal submission by the plaintiff's counsel was of a duty of care between Dr Woods and Patrick woods. Badgery-Parker J found in favour of the plaintiff on this

basis but the key issue was establishment of sufficient proximity between Dr Lowns and Patrick Woods.

In non-medical matters, the common law does not require persons to take actions to prevent injury or harm to another even when such injury or harm is foreseeable, as illustrated in *Sutherland Shire Council v Heyman*<sup>4</sup>; *Hawkins v Clayton*<sup>5</sup>; *Jaensch v Coffey*<sup>6</sup>.

In *Southern Shire Council*, the court held that no duty of care was owed by the local building authority to warn purchasers and occupiers of a property which had deficiencies in construction at the time of purchase but unknown to the authority because of inadequate inspection and only later discovered by the purchasers. There had been no contact between the authority and purchasers prior to purchase. Deane J argued that in order to satisfy a duty of care between parties there should be, (*inter alia*) the necessary requirement of proximity between the parties should involve several notions:

It involves the notion of nearness or closeness and embraces **physical proximity** (in the sense of space and time) between the plaintiff ... and the defendant, **circumstantial proximity** such as an overriding relationship of employer and employee or of a professional man and his client and what may (perhaps loosely) be referred to as **causal proximity** in the sense of the closeness or directness of the causal connection or relationship between the particular act or course of conduct and the loss or injury sustained. The requirement of a relationship of proximity serves as a touchstone and control of the categories of case in which the common law will adjudge that a duty of care is owed. Given the general circumstances of a case in a new or developing area of the law of negligence, the question what (if any) combination or combinations of factors will satisfy the requirement of proximity is a question of law to be resolved by the processes of legal reasoning, induction and deduction. On the other hand, the identification of the content of that requirement in such an area should not be either ostensibly or actually divorced from notions of what is "fair and reasonable" ..., or from the considerations of public policy which underlie and enlighten the existence and content of the requirement.<sup>7</sup>

Deane J had argued that although it was foreseeable that the building might contain deficiencies in construction, there had been no contact between the purchasers and the authority thus being insufficient proximity and no duty of care<sup>8</sup>.

In *Lowns v Woods* Justice Badgery-Parker followed the lead of Justice Deane and examined closely the facts of the case looking for circumstances which would exclude or include a duty of care by Lowns for Patrick Woods. He proposed that Dr Lowns was not in the position of a Good Samaritan when he received a request for emergency assistance but rather he was in a "professional context"<sup>9</sup>. When a doctor is practising his profession and deemed ready to undertake emergency care, he is acting in a "professional context". The emphasis is not only upon the physical proximity but also upon the circumstantial proximity which applied to Dr Lowns.

In addition, Badgery-Parker J stated that a medical practitioner is in a unique position in society by dint of training and qualification in that he is alone in the community to have the capacity (and privilege) to afford medical treatment when it is needed and by implication was a "fair and reasonable" requirement for proximity<sup>10</sup>.

Moreover, this notion of public policy was also reflected in the obligations imposed upon medical practitioners in the *Medical Practitioners Act 1938* thus strengthening the duty to treat a person in need<sup>11</sup>. He added further that the Act is not merely restricted to a pre-existing doctor-patient relationship because it deliberately (and advisedly) refers to “person” rather than “patient”<sup>12</sup>.

Thus by using the principles expounded by Deane J in *Sutherland Shire Council v Heyman* and in *Jaensch v Coffey*, Badgery-Parker J established that the missing aspect of proximity, that of circumstantial proximity whether it be an aspect of causal proximity or be separate, was satisfied. Physical and causal proximity *per se* were not in question. Accordingly, it was held that Dr Lowns owed Patrick Woods a duty of care and his refusal to attend and treat constituted a breach of such duty. The verdict against Dr Lowns for damages on behalf of Patrick Woods was \$3.2 million plus \$57,800 on behalf of Patrick’s father for nervous shock.

Permission was granted to appeal to the Supreme Court of New South Wales Court of Appeal consisting of Justices Cole, Mahoney and Kirby.

Cole JA and Kirby JA delivered the majority verdict, dismissing the appeal<sup>13</sup>. Cole JA reasoned that Dr Lowns owed Patrick Woods a duty of care based on a relationship of proximity created by S27 (2) *Medical Practitioners Act 1938* applicable in 1987 (notwithstanding that it did not stipulate opportunity for civil action upon breach). He rejected the defence advanced of being no sufficient proximity in particular of being no relevant physical proximity, any circumstantial proximity or any relevant causal proximity as explained by Deane J in *The Council of the Shire of Sutherland v Hayman*. Instead, he reasoned:

In my opinion this submission fails. Dr Lowns accepted that injury (“damage”) to a fitting child was foreseeable if he, once requested, did not attend to treat the child. There was an obvious physical proximity, for Joanna had come on foot. There also proximity in the sense that Dr Lowns was an adequate medical practitioner to whom a direct request for assistance was made in where, on the evidence presented, there was no reasonable impediment or circumstance diminishing his capacity or indicating significant or material inconvenience or difficulty in him responding to the request, in circumstances where he knew, as he must be deemed to have admitted once it is found the conversation occurred, that serious harm could occur to Patrick Woods if he did not respond to the request and provide treatment. Once it is found, as here, that administering valium at the time determined by the trial judge would have brought an end to the status epilepticus before the onset of brain damage causing quadriplegia, causal proximity is also established.<sup>14</sup>

Kirby JA, in distinguished this case from *Sutherland Shire Council v Heyman* (1985)<sup>4</sup> and from *Hawkins v Clayton* (1988)<sup>5</sup> which had established that the common law does not impose upon persons the duty of positive action to prevent injury or damage to others, by stating:

However, in the present case, that problem melts away because Dr Lowns himself acknowledged that within the ordinary standards of a local medical practitioner in his position, had he received the emergency call deposed by Mathew Woods’ sister, he would have been obliged to, and would in fact, have responded. This acknowledgment does not foreclose contrary evidence or prevent a contrary conclusion. But it is powerful testimony (confirming impressionistic understanding of ordinary medical practice on this State) as to what that practice requires.<sup>15</sup>

He cited the *Medical Practitioners Act 1938*, s27(2), as an indication of the accepted expectations amongst medical practitioners of the standard of care and while conceding it was high standard it was nonetheless what parliament, society and the medical community specified:

This is a high standard. It goes beyond what is expected, and imposed by the law, in the case of other professions. It goes far beyond what may be expected and demanded of an ordinary citizen. But in the noble profession of medicine, it is the rule which parliament has expressed; which the organised medical profession has accepted; and which Dr Lowns himself acknowledged and did not contest.<sup>16</sup>

He agreed with Cole JA by holding that:

...in the special circumstances, the relationship of proximity between Patrick Woods and Dr Lowns was established, notwithstanding their lack of previous professional association.<sup>17</sup>

Although he entertained doubt on the question of causation but after considering the circumstances of Patrick's fitting, physical proximity of Dr Lowns and possible difficulties with drug administration he concluded that had Dr Lowns responded to the request for urgent attention profound brain damage would probably have been avoided thus establishing duty, breach and causation.

Maloney JA vehemently dissented, saying that although there may have been a moral duty to attend, there was no professional duty and certainly no legal duty. He emphasized that hitherto there had been no legal obligation for a doctor to attend a person with whom no previous relationship existed and that to require that now would be against public policy and that the involvement of retrospectivity in creating civil law would be unjust. He noted that *The Medical Practitioners Act (1938)* imposed a moral and ethical duty, not a legal duty.

He doubted that there was even a professional obligation, or if there was, it should not be in absolute terms but in terms which allowed regulation:

The doctor called may or may not be (or be simply) a general practitioner. He may not deal with the problem the patient is said to have. He may be otherwise occupied. Any general practitioner will instance patients who call for help needlessly, who seek help at home which could and should be given at the surgery, or whose calls derive from emotional problems rather than actual illness. If professional sanctions are to be imposed, they will ordinarily be imposed in terms which do not impose an absolute obligation and they will be imposed in a way which allows regulation.<sup>18</sup>

He attacked the whole argument as based on the tort of negligence:

If the question be is this an act or omission to which the tort of negligence extends, that is not to be determined by asking (if it be) there is a duty of care. The issue here is not whether the doctor owed a duty of care to go to the child. If he did, his failure to do so whether deliberate or negligent, was a breach of his legal duty. His default, if there was one, was not one based on the tort of negligence; it was based on a tort or duty of a different kind.<sup>19</sup>

He remarked that the development of a new legal duty in this sphere should not be the task of the courts because it was subject to many qualifications and exceptions which should be considered by legislature. He noted in a wider sense in referring to the development of the tort of negligence:

... in my respectful opinion, none of these matters determines whether there is a duty as such upon a person having goods or skill to provide the benefit of them to another. It does not determine whether, because a person is (in whatever sense the term is used) a doctor, he has such an obligation.<sup>20</sup>

#### iv) Criticism of the *Lowns v Woods* decision

Numerous legal academics have criticised the decision. The points of attack have been proximity, causation, and an exception to a common duty.

Amirthalingam and Faunce<sup>21</sup> make a scathing attack. They state that: ‘... an analysis of *Lowns*, both at trial and appellate level, reveals a major doctrinal fault with its application of “proximity”’. They argue that the decision of Badgery-Parker J to find that a duty of care was owed to Patrick Woods by Dr Lowns was based on two general policy-based arguments. One was the clear statement of public policy in the *Medical Practitioners Act 1938* (NSW) in that a medical practitioner should attend a **person** (rather than a patient) who requires urgent treatment and the other was a public perception of high expectations of doctors. Badgery-Parker J used both of these public policies to define his concept of proximity which was also analysed similarly by Cole JA and by Kirby JA in interpretation of the *Medical Practitioners Act 1938* (NSW). In their opinion:

“The courts used “proximity” as a tool to *justify* the creation of a duty of care – the creation of which was based on policy – instead of using “proximity” as a negative criterion to determine whether or not a new duty of care ought to be recognised’. In addition these authors claim that the use of “proximity” was acontextual with Badgery-Parker J admitting that the key elements of “proximity” were merely “additional elements” rather than (as they should), an element of duty of care and should not be assessed in abstract”.

They argue that it should be used as Deane J used it in *Sutherland* such that:

“... reasoning process indicates clearly that “proximity” is a negative concept. Its purpose is to determine categories where a duty of care ought *not* to be recognised. It serves a limiting function to the reasonable foreseeability inquiry. It is not intended as an expansionary tool to create new categories of negligence where none existed before”.

Essentially it is argued that the decision in *Lowns* is based on admission by Dr Lowns that he had a moral duty (but not a legal duty) to attend and the decision has effectively created a new legal duty of medical practitioners to rescue. Such admission of a moral duty to rescue was used to embellish a relationship of “proximity” between the doctor and the plaintiff.

Their argument has plausibility but extends beyond reason:

“There was no relationship of “proximity” between Woods and Lowns. There was no policy consideration that could change that. It appears that a duty of care was imposed not on the basis of a relationship of “proximity”, but simply

because there was an unfortunate plaintiff who needed compensation and the court felt he should have it.”

Amirthalingam and Faunce hint at a loss of personal liberty when they state that such:

“(this) legal duty puts the medical practitioner at the service not only of the community but also of the State”.

This concept is explored in more detail by Gray and Edelman<sup>22</sup> and they suggest that the common law can recognise a limited duty to rescue without contravening personal liberty. In taking a limited view of the scope of rescue, they suggest that this is possible when rescue is the very thing for which some members of society are trained such as doctors, lifeguards, firefighters, police and coastguards. They claim that Dr Lowns, by holding himself out as practising medical practitioner, entered a special relationship with Patrick Woods who was vulnerable and dependent upon Dr Lowns’ skill, irrespective of previous lack of doctor-patient relationship, and irrespective of the provisions of the *Medical Practitioners Act 1938* (NSW).

Gray and Edelman maintain that proximity can recognise a duty to rescue, but in their view the approach taken to circumstantial proximity in *Lowns*, was unsatisfactory. They maintain that the court used the availability of Dr Lowns (in that he was close by, available and ready to work) to satisfy the concept of circumstantial proximity and by doing so failed to distinguish circumstantial proximity from physical proximity and thus did not properly establish the existence of an “overriding relationship” between rescuer and the victim. They maintain that the duty of care in argument in *Lowns* was satisfied by public policy. They maintain that circumstantial proximity is the essential requirement to establish a duty of care, not the duty to rescue, and it is the special skills of the potential rescuer which defines the duty to rescue. Furthermore, they state that this duty is logically extended to all classes of persons who are in positions of “control” over others, for example, for surf life-savers to protect swimmers from surf-board riders or for teachers to protect students from other students. Logically, the duty to rescue extends to all professionals who have rescue as part of their work, the obvious being practising doctors, whether they are on duty or not. They suggest the principle should be applied more broadly when “rescue” is considered in various contexts such as the duty of a security guard who observes an assault or a volunteer firefighter to respond to a call of fire.

Melnitchouk<sup>23</sup> contends that doctors practising in states other than New South Wales and the Australian Capital Territory which do not have legislation akin to that described in The *Medical Practitioners Act 1938* (NSW) or *Medical Practitioners Act 1930* (ACT) will not be subject to the same duties to render emergency care to a person with whom they have had no previous relationship. The reasoning is that Badgery-Parker J established circumstantial proximity and a duty of care between Dr Lowns and Patrick Woods by relying on the “very clear statement of public policy” in the Act and a request to attend made in a professional context *i.e.* that Dr Lowns was ready to work, available and had no impediment preventing him attending. The majority reasoning on appeal by Kirby JA and Cole JA was similar to that of Badgery-Parker J. Added to this, Melnitchouk implies that Dr Lowns was not adequately defended in that the only argument advanced in his favour was that he did not have any conversation with Joanna Woods. Instead, it points of law should have been raised as by dissenting Mahoney JA who emphasized that there was confusion between a moral and professional obligation to attend a legal obligation.

Day<sup>24</sup> argues that the extension of the tort of negligence based on community values by reference to proximity is contentious. On a State-to-State basis, the duty of a medical practitioner to attend to emergencies is likely to be predicated on the exact wording of legislature. Only in NSW and ACT is it clear that doctors should attend. In other States however, the Court's reliance on proximity giving rise to a duty of care and a request made in a professional context care may be enough to establish a common law duty. Alternatively, it is argued, another State may follow the reasoning of the minority judgement on appeal in which Mahoney JA put forward, with the convincing arguments that Dr Lowns was not liable in tort of negligence, not subject to legal statutory requirement and unjustly the victim of retrospectivity.

Haberfield<sup>25</sup> also maintains that the majority decision was unsatisfactory. It failed to justify the decision against the long-standing principle that no duty is owed by one person to rescue another in danger and failed to establish how Dr Lowns could have been negligent. The essence of the argument is that proximity should be applied only to a misfeasance and cannot be applied to a non-feasance. Therefore, it is argued, the difficult problem of causation for an omission remains unexplained and cannot get around the general rule that no duty is owed. Put another way, the majority decision failed to explain how Dr Lown's non-action satisfied the necessary element of causation in the tort of negligence. Moreover, it is argued that the decision is an exception to the "no duty to rescue rule" and does not fit in with other exceptions created in common law. This case is more than an exception to the rule, the decision it is claimed is an attack upon the rule itself yet no unifying principle among exceptions was identified. A call is made for legislation to sort out the growing confusion in common law on the duty to rescue.

Crowley-Smith<sup>27</sup> simply states that the argument for negligence in *Lowns* based on proximity is simply not clear but does not analyse them in depth, instead using the decision to call for introduction of Good Samaritan legislation.

#### **v) Common Law Cases against Medical Practitioners in Other Jurisdictions**

In *Hurley v Eddingfield*<sup>27</sup>, a general practitioner of medicine in the State of Indiana was requested to attend a seriously ill woman but he declined to do so for no obvious or declared reason, despite the fact that he was the sole available physician. The woman subsequently died. The alleged wrongful act of the doctor was his refusal to enter a contract. The Supreme Court held that he was not obliged to practice medicine and was free to practice on any terms of his choosing.

In *Childers v Frye*<sup>28</sup>, a young man in North Carolina was brought to a hospital after alleging falling from a moving vehicle and striking his head. A doctor was consulted but he diagnosed a state of alcoholic inebriation, sent him home with friends with instructions to bring him back if full consciousness was not resumed. However, the man died after several days from brain injury despite treatment by other physicians. It was alleged that the doctor negligently failed to conduct a proper examination. The doctor's denied that he had never accepted him as a patient. The Court on appeal held that the doctor was not obliged to accept the injured man as a patient under contract.

In *Butterworth v Swint*<sup>29</sup>, a woman in Georgia who was an employee of a hospital brought a malpractice action against the physician superintendent who merely gave advice not as a physician about an abdominal condition but which required surgery. On appeal the court held that no physician-patient relationship had been created by their work relationship and he was not required to treat her.

In *Findlay v Board of Supervisors of County of Mohave* (1951)<sup>32</sup> 230 P 2d 526, the Supreme Court of Arizona held that physicians are not public servants bound to serve all who seek them, and they are under no obligation to engage in practice or to accept professional employment.

In *Agnew v Parks*<sup>31</sup>, an appeal court in California held that a doctor is not obliged to render services as an expert witness on behalf of a person with whom no relationship has been formed by way of contract to examine or treat.

In *Hiser v Randolph*<sup>32</sup>, a malpractice suit in Arizona was brought against a doctor who refused to attend a diabetic woman who presented to the emergency department of a hospital where the doctor had contracted to be 'on call'. He stated that the woman should be attended by her regular physician who was familiar with her condition, having treated her the previous day but who on being contacted could not attend. A third doctor attended after a delay of some 40 minutes but the woman died the next day. The appeal court held that despite the contract between the defendant and the hospital, he was not obliged to render service because no previous doctor-patient relationship had been formed.

In *Childs v Weis*<sup>33</sup>, a pregnant woman in early labour attended the emergency department of a hospital in Texas. A nurse telephoned the doctor on call but he refused to attend saying the woman should return to her home city and to the care of her usual doctor. Shortly after leaving the hospital the woman gave birth but the infant died. It was held that since no doctor-patient relationship had existed he was under no duty to treat.

In *Rodriguez v New York City Health & Hospitals Corporation*<sup>34</sup>, a medical practitioner, coming across a seriously ill man (who later died) by chance while not working was sued for malpractice by the wife of the victim because he departed the scene after assessing the situation and calling an ambulance. The court held that, under emergency conditions after arranging transport of the victim to hospital, he was not guilty.

#### **vi) Implications of *Lowns v Woods* for Good Samaritans and Volunteers**

Effectively, the judgement in *Lowns v Woods* puts into common law a moral or ethical sentiment which had been expressed in the former *Medical Practitioners Act 1938* (NSW) *i.e.* that doctors are obliged to treat in an emergency if so requested.

The parable of the Good Samaritan is well known and does not warrant repetition but the relationship between the rescued and the rescuer deserve some mention in the context of present day provision of aid. In that story, the rescuer had no responsibility to offer or provide help, but did so without request. There was no connection between the Samaritan and the injured. The help that was provided was not specialised and of a nature that any person could have rendered. The rescuer was in close proximity, passing by on some other errand and came across the injured without warning.

In our present community we encourage bystanders to give assistance to distressed persons. Multiple professional, non-professional and charitable organisations band together to support that endeavour, constituting the Australian Resuscitation Council. Member organisations (and others) they train novices in the art of first-aid and resuscitation and openly declare that "Any attempt (to rescue) is better than no attempt at all"<sup>2</sup>. This exhortation is a result of the realisation that chance of survival from cardiac arrest diminishes by 10% for each passing minute and that simple first-aid manoeuvres can be life-saving<sup>35</sup>.

Setting aside any moral or philosophical argument, it appears that society expects medical personnel to do more than merely act as Good Samaritans as illustrated by *Lowns v Woods*.

The *Medical Practice Act 1992* (NSW) s 36 (which replaces *Medical Practitioners Act 1938*) also deems failure to render medical aid in an emergency as unsatisfactory medical professional conduct. Its wording is very similar and will have the same significance:

Refusing or failing, without reasonable cause, to attend (within a reasonable time after being requested to do so) on a person for the purpose of rendering professional services in the capacity of a registered medical practitioner in any case where the practitioner has reasonable cause to believe that the person is in need of urgent attention by a registered medical practitioner, unless the practitioner has taken all reasonable steps to ensure that another registered medical practitioner attends instead within a reasonable time.

A *ratio decidendi* which may be extracted from *Lowns v Woods* is:

Irrespective of the common law which does not oblige persons to take positive action to prevent foreseeable harm to others and when a prior doctor-patient relationship does not exist, a practising medical practitioner at work has a duty of care to respond to a request for emergency assistance when sufficient proximity exists and when it is foreseeable that failure to attend will cause injury.

In a broader sense this may apply to other persons in society who possess skills of less specialised than those possessed by a medical practitioner but which may be nonetheless equally 'life-saving' or 'injury-preventing'. This would be most applicable to members of organisations which hold themselves out as having special skills such as those of St John Ambulance or Surf Life-saving organisations. Skills may be for example the application of rescue breathing (mouth-to-mouth, expired air resuscitation) for a nearly drowned victim or recently the subject of heart attack in which application of external cardiac massage may be beneficial. Indeed such skills are possessed in high standard by members of numerous first-aid organisations who could arguably perform such better than general medical practitioners. In these instances such as these, it is the physical proximity of the by-stander whose first-aid actions are most valued.

However, this is not the sentiment that has driven legislatures to enact legislation for the so-called protection of Good Samaritans. It has been the fear of litigation spurred by a crisis in the cost of provision of indemnity as illustrated by Premier Carr speaking to the Civil Liability Amendment (Personal Responsibility) Bill <sup>36</sup>.

## **2. GOOD SAMARITAN and VOLUNTEER LEGISLATION**

All States and Territories except Tasmania and Western Australia have legislation concerning the liability of "Good Samaritans" and Volunteers, some made after the Review of the Law of Negligence ('Ipp Report') <sup>37</sup>.

Whether there was any necessity to do that a public point of view is debatable. There seems to exist a fear of litigation on behalf of Good Samaritans and volunteers. The incidence of law suits against Good Samaritans and volunteers is extremely low and

none have been successful. For example, St John Ambulance (Australia) registered six incidents of alleged negligence against its members from attendances at approximately one million casualties over a ten year period, and none of those were successful ('Tito Report')<sup>38</sup>. Nonetheless, the fear is genuine and may explain the impetus to rush to legislation.

The predominant issues are the assistance and the standard of assistance given to persons in need or apparent need. Good Samaritans and volunteers are concerned that if they assist a person in need of assistance, they may be sued. From a legal point of view, legislation to exempt Good Samaritans and volunteers is probably unnecessary. Indeed, the Ipp Report made a recommendation against it:

The panel's view is that because of the emergency nature of the circumstances, and the skills of the Good Samaritan, are currently taken into account in determining the issue of negligence, it is unnecessary, and indeed, undesirable to go further and to exempt Good Samaritans entirely from the possibility of being sued for negligence. A complete exemption from the liability for rendering assistance in an emergency would tip the scales of personal responsibility too heavily in favour of interveners and against the interests of those requiring assistance. In our view, there are no compelling arguments for such exemption.<sup>39</sup>

A "Good Samaritan" is defined variously as a person who in good faith and without expectation of payment or reward comes to the aid of an injured, apparently injured or person at risk of injury reward with assistance or advice. Differences in legislation among States and Territories may serve to increase public distrust in the legal process.

### **i) New South Wales**

The *Civil Liability Act 2002* (NSW) has sections related to both Good Samaritans and Volunteers .

#### **Good Samaritans**

The *Civil Liability Act 2002* exempts a Good Samaritan from personal civil liability in respect of any act or omission when giving assistance (S57)(1) but does not affect the vicarious liability of any other person for the acts or omissions of the Good Samaritan (S57)(2). Moreover, such protection is excluded if the Good Samaritan's intentional or negligent acts or omissions caused the injury (S58)(1), if the Good Samaritan is under the influence of alcohol or drug voluntarily consumed (S58)(2)(a) or the Good Samaritan failed to exercise reasonable care and skill in connection with the act or omission (S58)(2)(b) and does not extend to persons impersonating a health care worker, emergency services worker or police officer or other person falsely claiming skills (S58)(3).

#### **Volunteers**

Under the *Civil Liability Act 2002*, a volunteer does not incur any personal civil liability in respect to any act or omission done or made in good faith when doing community work organised by a community organisation or as an office holder of a community organisation (61)(a)(b).

In the Act, a community organisation is defined (60) as any that organises community work by volunteers and that is capable of being sued for damages in civil proceedings and includes a body corporate, a church or other religious organisation or an authority of the State. Community work means work that is not for private financial gain and that is done for charitable, benevolent, philanthropic, sporting, educational or cultural purpose, and includes work declared by the regulations to be community work but does not include work declared by the regulations not to be community work. A volunteer means a person who does community work on a voluntary basis. Work includes any activity except that done under an order of a court and permits receipt of reimbursement for reasonable expenses.

Liability is not excluded if the volunteer at the time of the act or omission was engaged in conduct that constitutes an offence (62), or under the influence of alcohol or drug voluntarily consumed or failed to exercise reasonable care and skill (63) or was acting outside the scope of activities authorised by the organisation or contrary to its instructions (64) or when the liability is required by State law to be insured against (65).

#### *State Emergency and Rescue Management Act 1989 (NSW)*

Many volunteers in the community do work related to rescue within non-government emergency services. Examples are surf rescue, body recovery, ski safety patrols, and aerial and marine patrols (Debnam 2002, 5764)<sup>40</sup>. They are not included, or could be included under Part 9 of the *Civil Liability Act 2002*. An amendment by way of the *Civil Liability Amendment (Personal responsibility) Act 2002* was added section 59 of the *State Emergency and Rescue Management Act 1989*. Accredited rescue units, persons as members of an accredited rescue unit, authorised volunteers or casual volunteers are not, if acting or omitting action in good faith in connection with a rescue operation or otherwise in response to an emergency, subject to any action, liability, claim or demand. For the purpose of the Act, an accredited rescue unit includes surf life-saving units and any organisation or agency (other than a government agency) that manages or controls an accredited rescue unit. An authorised volunteer means a person who assists an accredited rescue unit in carrying out rescue operation with the consent of the person in charge of the rescue operation while a casual volunteer means a person who assists, on his or her own initiative, in a rescue operation or otherwise in response to an emergency in circumstances in which the assistance was reasonably given.

Despite the specific reference to rescue organisations in New South Wales, their immunity to liability remains uncertain. Eburn points out that if an organisation is vicariously liable for its volunteer members, the *Civil Liability Act 2002* will exempt the volunteer but not the organisation to which he or she belongs. Indeed, in the premier's second reading speech for the Bill there appears to be a conflict of aims of the Act:

This will mean no liability for voluntary rescue organisations, such as surf life saving clubs, if a person is injured in the course of or in connection with a rescue. Individual volunteers will also be protected from law suits where their actions were done in good faith. It is not intended to alter the potential liability of a community organisation by providing individual members with immunity.

<sup>41</sup>

#### **ii) Victoria**

## **Good Samaritan**

The *Wrongs Act 1958* (Vic) exempts a Good Samaritan from liability in any civil proceeding for anything done, or not done, by him or her in good faith in providing assistance, advice or care at the scene of the emergency or accident (31A)(2)(a) or in providing advice by telephone or by another means of communication to a person at the scene of the emergency or accident (31B)(2)(b). This applies even if the emergency or accident was caused by an act or omission of the Good Samaritan (31B)(3) but does not apply to any act or omission of a Good Samaritan that occurs before the assistance, advice or care is provided by the Good Samaritan (31B)(4).

## **Volunteer**

A volunteer is defined as an individual who provides service in relation to community work on a voluntary basis (35) but does not preclude the receipt of remuneration that he or she would receive whether the service be provided or not (2)(a); or out-of-pocket expenses (2)(b).

For the purpose of the Act, people are not volunteers (3) if; acting as a volunteer officer or member within the meaning of the *Country Fire Authority Act 1958* while exercising within that Act or under the *Dangerous Goods Act 1985* (a)(b); or a volunteer auxiliary worker within the meaning of the *Country Fire Authority Act 1958* (c); or a person complying with a direction given to him or her under the *Country Fire Authority Act 1958* (d); or a volunteer emergency worker within the meaning of the *Emergency Management Act 1986* working under the Act or under the *Victoria State Emergency Service Act 1987* (e)(f); or any person who would otherwise be a volunteer under this part (3) while he or she is engaged in any activity in respect of which an Act absolves him or her from civil liability for anything done, or not done, while he or she is so engaged (g); or a person who does community work under a court order (h).

Community work is defined (36) as any work that is done, or to be done for the purposes of religion, education, charity or benevolence (a); promotion or encouraging literature, science or the arts (b); promotion of sport, recreation, tourism or amusement (c); conserving or protecting the environment (d); establishing, carrying on or improving a community, social or cultural centre (e), politics (f); promoting common interests of the community generally or of a particular section of the community (g).

A volunteer is not liable in any civil proceeding for anything done, or not done, in good faith by him or her in providing a service in relation to community work organised by a community organisation (37)(1). However, any liability resulting from an act or omission that would but for sub-section (1) attach to the volunteer attaches instead to the community organisation (37)(2). Section 37 (1) does not apply to a volunteer (a) who knew, or who ought reasonably to have known, that at the relevant time he or she was acting (1) outside the cope of the community work organised by the community organisation; or (ii) contrary to the instructions given by the community organisation in relation to the providing of the service; or (b) whose ability to provide the service in a proper manner was, at the relevant time, significantly impaired by alcohol or drugs. The reference to drugs (1)(b) does not include a reference to drugs that were taken for a therapeutic purpose or that were not taken voluntarily (3) and a reference to alcohol in sub-section (1)(b) does not include a reference to alcohol that was not consumed voluntarily (4).

A community organisation is liable in any civil proceeding for anything done, or not done in good faith by volunteers in providing service in relation to community work organised by the organisation (37)(2). If more than one community organisation is involved, liability applies to the community organisation or organisations that principally organised the work (39)(2). If the community organisation is a public authority or agency within the meaning of the *Public Sector management and Employment Act 1998* or another person or body acting on behalf of the State, any liability incurred under section 37 (2) is incurred by the State (39)(3).

### **iii) Queensland**

Under the *Law Reform Act 1995* (Qld) a medical practitioner, nurse or other person prescribed under a regulation is not liable for an act done or omitted in the course of rendering medical care, aid or assistance to an injured person in circumstances of emergency at or near the scene of the incident or emergency or while the injured person is being transported to a hospital or other place where medical care is available (16)(a,b). However, this exemption does not apply in gross negligence (16)(c).

### **iv) South Australia**

The *Wrongs Act 1936* (SA) exempts Good Samaritans from personal civil liability for an act or omission in good faith and without recklessness in assisting a person in apparent need of emergency assistance (38)(2) but does not operate if the Good Samaritan's capacity to exercise due care and skill was, at the relevant time, significantly impaired by alcohol or another recreational drug (38)(4)(b).

In this Act, Good Samaritan means apart from any 'person' (1)(a), a medically qualified person (38)(b) who is; a registered medical practitioner; or has professional qualifications in some field of health care that are statutorily recognised; or works or has worked as an ambulance officer in some other recognised paramedical capacity.

Medically qualified persons incur no liability for advice about the assistance to be given to a person in apparent need of emergency medical assistance (38)(3).

### **v) Australian Capital Territory**

#### **Good Samaritan**

The *Civil Law (Wrongs) Act 2002* (ACT) exempts a Good Samaritan from personal liability for an act done or omission made honestly and without recklessness in assisting, or giving advice about the assistance to be given to a person who is apparently injured or at risk of being injured or in need of emergency medical assistance (5)(1). However, this not apply if the Good Samaritan's capacity to exercise appropriate care and skill was, at the relevant time, significantly impaired by a recreational drug (5)(2).

A Good Samaritan means (5)(3) a 'person' or a 'medically qualified person' whose definition is essentially the same as that given in the *Wrongs Act 1936* (SA). Exemption also applies to a medically qualified person who gives advice by telephone or another form of telecommunication about the treatment of a person who is apparently injured or at risk of being injured or in need of emergency medical assistance.

## **Volunteer**

A volunteer means a person who carries out community work on a voluntary basis. Volunteers do not incur personal civil liability for an act or omission made honestly and without recklessness while carrying out community work for a community organisation on a voluntary basis.

Community work is defined (7)(1) and is essentially the same as described by the *Wrongs Act 1958* (Vic). The protection does not apply (8)(2) if the volunteer's capacity to carry out the work properly, was at the relevant time, significantly impaired by a recreational drug; or the volunteer was acting, and knew or ought to have known that he or she was acting; outside the scope of the activities authorised by the community organisation; or contrary to instructions given by the community organisation.

Community organisations are liable for their volunteers (9)(1). An injured person may sue the volunteer personally only if the organisation disputes, in a defence filed to the action, that it is liable for the act or omission of the volunteer (9)(2). The Territory may assume liability of community organisations for volunteers (10).

### **vi) Northern Territory**

The Criminal Code Act section 155 specifies that 'Any person who, being able to provide rescue, resuscitation, medical treatment, first aid or succour of any kind to a person urgently in need of it and whose life may be endangered if it is not provided, callously fails to do so is guilty of a crime that any person is guilty of a crime and liable to imprisonment for seven years'

In *Salmon v Chute*<sup>42</sup>, the driver of a vehicle which struck a child who had run in front of the vehicle failed to stop. The driver was convicted under s 155 and sentenced to 12 months imprisonment. However, on appeal the conviction was quashed on the basis that failure to stop did not contribute to death *i.e.* it would have occurred regardless, that the driver had no resuscitation or first-aid skills and that the act was not callous.

### **vii) Significant Differences and Similarities between States and Territories**

New South Wales, Victoria and Australian Capital Territory have legislation which exempts liability for both Good Samaritans and Volunteers. In South Australia the legislation applies only to Good Samaritans and in Queensland it applies only to volunteers. Western Australia and Tasmania have no legislation which applies to either.

In the Northern Territory, it is a criminal offence by any person not to rescue or provide resuscitation, medical treatment, first-aid or succour to any person whose life is endangered.

### **Who is a Good Samaritan?**

South Australian and Australian Capital Territory legislation applies to any unspecified person or to a 'medically qualified person' who gives advice. In the former category are medical practitioners, a person with a statutorily recognised professional qualification in the some field of health and ambulance officers. In New

South Wales, Victoria and Northern Territory, legislation applies to unspecified 'persons' or 'individuals'.

### **Who is a Volunteer?**

Queensland legislation is restricted to doctors, nurses and other prescribed persons under regulation (unspecified). In New South Wales, Victoria and Australian Capital Territory a volunteer is a person who does community work on a voluntary basis.

### **Waiver of liability for Good Samaritans and Volunteers**

- a) Liability is waived for Good Samaritans in New South Wales, Victoria, South Australia and Australian Capital Territory even if the Good Samaritan caused the injury in Victoria but not in New South Wales.
- b) Liability is waived for volunteers in New South Wales, Victoria, Queensland and Australian Capital Territory
- c) Liability is not waived if the Good Samaritan or volunteer is under the influence of alcohol or recreational drug (SA, ACT) or alcohol or drug irrespective of whether it is medication (NSW). Victoria is silent on this matter.
- d) Liability is not waived if the Good Samaritan or volunteer in New South Wales fails to exercise reasonable care and skill; if the Good Samaritan acts with recklessness in South Australia and Australian Capital Territory; if the volunteer in Queensland acts with gross negligence. Victoria is silent on this matter.

### **viii) Need and Impact of Good Samaritan Legislation**

Several other jurisdictions have enacted which waiver liability for Good Samaritans. All 50 States in United States of America (USA) have enacted Good Samaritan laws<sup>43</sup>. In some States, such as Nevada, the laws apply to all citizens. Some states such as California have special Good Samaritan laws which apply to doctors and to doctors acting as a Good Samaritan within the hospital context<sup>43</sup>. A restricted number of States (Vermont, Louisiana and Minnesota) have laws which are very similar to the Northern Territory which oblige any person to act to assist a needy victim. Numerous European societies have laws which similarly compel the provision of emergency assistance for those in need.<sup>45,46</sup>

However, the need of such laws is debatable. Despite the apparent litigious nature of American society, no case has brought against a doctor for providing emergency aid outside a hospital<sup>47</sup>. On the other hand, doctors seem reluctant to offer emergency assistance but it may not be because of fears of prosecution. For example, in a study in 1998, 69% of doctors would give aid to a man complaining of chest pain in a restaurant and 54% would respond to a call for help on an airplane but only 2% would help a dishevelled man lying on a footpath<sup>48</sup>. Of significant importance in that study was that knowledge of the local State Good Samaritan law was not associated with willingness to help. Similar studies in previous years including one in 1964 showed that 50% of doctors would respond to a call for emergency assistance<sup>46</sup>. One study suggested that introduction of a law was associated with a slight decrease in avowed response rate<sup>46</sup>.

A review of the Good Samaritan legislation in Canada in 1992, when its development was at the approximate stage of such legislation in Australia, contains some pertinent observations<sup>46</sup>. At that time, 8 provinces and territories had enacted legislation and 3

of 4 provinces had rejected as being otiose. Among those States enacting legislation, there existed a variation in the class of citizen protected, the site of protection, gratuity requirement for service and whether the assistance should be voluntary. The only commonality among the provinces and territories was the standard of care which was gross negligence, which was recommended. Cogent reasons for introduction of such legislation was lacking. It was suggested that the existing common law rules and the realities of litigation served to limit the victim's ability to recover damages. It was suggested that the better way to encourage rescue was to simply educate potential rescuers to the fact that rescue entails a negligible risk of liability.

The question of whether Australia should introduce legislation was addressed by Crowley-Smith<sup>26</sup>. It was argued that legislation should be introduced after venturing to comment that as a consequence of *Lowns*: "it is only a matter of time before a gratuitous health care rescuer in Australia will be faced with a civil action for tortious acts". Notably however, no evidence of this viewpoint could be found in the North American experience. Saliiently, it was noted that since Australia needs "Good Samaritanism" and "Given the potential for litigation for simple failure to rescue ... perhaps the best solution is to do away with duty to rescue altogether".

The law Reform Committee of Victoria in 1997 recommended introduction of Good Samaritan legislation<sup>49</sup> based on the decision in *Lowns* and because it had received submissions from "a great many doctors and nurses who will not offer any level of medical attention on the street (ie outside of their clinic, rooms or hospital) due to fear of malpractice suits".

## **B) THE STANDARD OF CARE and ITS DETERMINATION**

### **1. COMMON LAW**

Under common law it is now the case that the standard of care is that required of a reasonable person with the skills of the rescuer, whatever they may be, but that it remains for the court to determine the standard.

As noted previously, no cases involving the standard of care given by volunteers have come before the Australian courts. However, Eburn cites a case in England, *Cattley v St Johns Ambulance Brigade*, (1988) (unreported), Q.B.D., in which the court held that a St John Ambulance officer was not negligent if performing according to training even if that was inadequate<sup>50</sup>.

In *R. v Bateman*, a case involving a medical practitioner whose management contributed to the death of a patient, Lord Hewart CJ said:

The law as laid down in these cases may be thus summarised: if a person holds himself out as possessing skill and knowledge and if consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment.<sup>51</sup>

Determination of the standard of care in the tort of negligence has a long development but finds direct relevance in the standard of medical care in the case of *Bolam v Friern Hospital Management Committee* in which McNair J stated:

... a doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, merely because there is a body of such opinion that takes a contrary view.<sup>52</sup>

This became known as the *Bolam* principle and served as the standard of care.

However, cases occurred where there was conflict of opinion between equally responsible medical men as in *Bolitho v City and Hackney Health Authority*. In the decision Lord Browne-Wilkinson remarked:

... in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice.<sup>53</sup>

In that case and in others cited, including *Hucks v Cole* (1993) 4 Med LR 393 in which a doctor failed to treat with penicillin a patient who had septic skin lesions susceptible to such treatment but whose management was supported by other distinguished doctors, he remarked:

... in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of professional opinion is not reasonable or responsible.<sup>54</sup>

The *Bolam* principle was rejected in Australia in the case of *Rogers v Whitaker*<sup>55</sup> in which a medical practitioner failed to warn a patient of the remote risk of blindness due to sympathetic ophthalmia in her fully functioning eye when she underwent surgery on the other in which she was partially blind. Although this case involved the standard of disclosure of risk, the appeal judges stated:

In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill ... But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade... Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam* principle has not always been applied ... Further ... the *Bolam* principle has been discarded and, instead, the courts have adopted ... the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care ...<sup>56</sup>

Subsequently, this rejection of the *Bolam* principle as related to provision of information to a patient was adhered to in *Rosenberg v Percival*<sup>57</sup> and extended to diagnosis and treatment in *Naxakis v Western General Hospital*<sup>58</sup>.

Consultations by the panel of the Review of the law of Negligence suggested that there was a significant body of opinion, especially among the medical profession, in favour of reinstating the *Bolam* principle in its original form. However, the panel chose to make a recommendation (recommendation 3) as a reinstatement in a modified form as:

A medical practitioner is not negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected

practitioners in the relevant field, unless the court considers that the opinion was irrational.<sup>59</sup>

The panel's recommendation was specifically for medical practitioners but added that when legislation is enacted, it should be in such terms as to leave it open for the courts to extend the rule to other occupational groups (undefined).

## **2. LEGISLATION**

Notwithstanding the recommendation of the "Ipp Report"<sup>37</sup> against Good Samaritan legislation, the parliaments of New South Wales, Victoria and Australian Capital Territory have enacted legislation which includes sections related to the standard of care related to "professionals" or persons who claim to have special skills. Generally, the standard of care required is that of a person with the skills of the rescuer acting with care.

### **i) New South Wales**

The Civil Liability Act 2002 (NSW) section 5O (1) specifies that a person practising a profession does not incur liability in negligence if acting in a manner which is widely accepted in Australia by peer professional opinion at the time of action. However, it is the duty of the court to decide if the opinion offered by peers is acceptable (2)(3)(4).

### **ii) Victoria**

The *Wrongs Act 1958* (Vic) division 5 relates to negligence of professionals and persons professing particular skills. The standard of a professional is one accepted in Australia by a significant number of respected practitioners in the field as competent practice in the circumstances (59)(1) but it is left to the court to determine if the professional opinion is reasonable and can be relied upon (2)(3)(4). In the case of a person holding out as possessing a particular skill the standard is that which could be reasonably expected of a person possessing that skill in the circumstances and at the time of the alleged negligence (58)(a)(b).

### **iii) Australian Capital Territory**

Section 42 of the *Civil Law (Wrongs) Act 2002* (ACT) specifies the standard of care required for a person to determine negligence is that of a reasonable person in the rescuer's position who was in possession of all the information, or ought reasonably to have had, at the time of the incident out of which the harm arose.

## **C) CONCLUSIONS**

Stemming from the *Lowns v Woods* decision, it is likely that volunteers, while on service owe a duty to rescue. This is most likely in New South Wales where common law has established this for medical practitioners and where legislation obliges medical practitioners to render assistance in emergencies. In Australian Capital Territory, it is possible that a similar obligation would apply because of similar legislation which requires a medical practitioner to attend to emergencies. In the remaining States and Territory the situation is uncertain since there exists no specific legislation and *Lowns v Woods* decision is not binding.

When not on duty however, volunteers would be in the same position as Good Samaritans and have no duty to rescue.

However, if action is undertaken, whether by Good Samaritans or volunteers, there is a possibility of a tort of negligence. The standard of care in all States and Territories required of a rescuer to avert a successful charge of negligence is that of a reasonable person in the same position of the rescuer at the time at which the incident of rescue occurred. The courts will determine in common law or with reference to legislation what the standard of care should be given notwithstanding the opinion of peer group opinion. However, considering the incidence of such litigation, the threat is minute although the fear of such is tangible.

For whatever reasons, perhaps to offset the fear of litigation, most States and Territories except Tasmania and Western Australia have enacted Good Samaritan or volunteer legislation in which the liability for action done or omission in good faith is waived unless the acts or omission have been with recklessness or with gross negligence. In other words, the standard of care is low.

The Northern Territory has unique legislation which mandates assistance to any person in need by any other person irrespective of status.

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