Letter from James O. Page to
Aurora Colorado Fire Department,
Sept. 28, 1981

Dear Ms. Blackwood,

This is response to your letter of September 22nd. To the extent that my response deals with legal issues, I will respond in general terms, based on my understanding of the national experience (or lack thereof) with these similar issues. I presume that ultimately you will be guided by the advice of your local municipal legal counsel.

Specifically, your questions are as follows:

(1) What are the legal implications for dispatchers who have had only a twenty-one hour course in the use of this card system (your newly-instituted Medical Self-Help Dispatch Program), eleven hours of which included basic CPR and CPR Instructor’s training, when they begin giving CPR instruction over the telephone, and the victim dies?

(2) If a dispatcher successfully gives CPR instruction, or any other aid, over the telephone to one individual, but is unable to give the same to another person who calls in because of a rash of alarms at the time of the call or other circumstances beyond his/her control, can the dispatcher be held liable?

(3) What is your professional opinion of the necessity and/or importance of such a program as this one?

On the subject of civil liability, as it relates to cardiopulmonary resuscitation (CPR), we have been quite vocal. For example, in September, 1977, in our EMS Action publication, we published an article entitled “CPR and Red Herring.” Coincidentally, in the same issue, we published a story about the innovative dispatching system in Phoenix. Our article (about CPR) produced a heavy demand for reprints. Thus, we created a pamphlet entitled “CPR and the Law.”

We feel that the legal issues (or non-issues) are very clear. A person who needs CPR is pulseless and non-breathing. That is the state of the victim at the time the call is received by the dispatcher. The dispatcher did not cause the victim to be a pulseless, non-breathing state. There is no way the victim can be made worse. If the effort to direct CPR by phone fails, the victim is no worse off than s/he was when the dispatcher received the call and offered assistance via CPR instruction. If the victim services (even for a brief period, or even in a vegetative state), s/he is better off than when s/he was clinically dead. There can be no liability for a good faith effort that fails, of for leaving a person better off.

The length of the course undertaken by your dispatchers (in terms of hours) is relatively insignificant. In the unlikely event of a lawsuit, their performance in the particular care would be at issue, not the length of their training program. Millions of lay persons have learned to perform CPR competently in courses as short as three hours. Whether they took a three-hour course or a twelve-hour course is not significant from either legal or medical points of view. The issue is how well the individual perform when called upon to respond in an actual emergency?

If a CPR-trained dispatcher permits his/her knowledge and skills to deteriorate (does not engage in periodic refresher training), and if that dispatcher issues inappropriate instructions to a caller, there could be cause for concern (more medical and ethiciz than legal, in my opinion). For example, if the dispatcher fails to follow the protocol for airway, breathing, and circulation, and thereafter instructs the caller to perform CPR. If the victim simply has fainted, there could be legal difficulty.

The New Jersey case of In re Roy (362 A2d589 (1976)) may be illustrative... In that case, untrained police officers and volunteer ambulance personnel performed a technique on Mrs. Roy that was described as “vigorously pounding on the chest.” As the medical examiner reported, Mrs. Roy had merely fainted and had not suffered a heart attack. The autopsy revealed that her death was caused by the thoroughly unskilled
rescue effort. Had the police officers and ambulance personnel been properly trained, they would have known enough to conduct the essential airway, breathing, and circulation checks before initiating their resuscitative effort, and they would have known how to support the victim’s vital functions without causing fatal injuries.

It should be noted that the Roy case is not a CPR case. The defendants were not trained in CPR and they did not perform CPR as it was taught them (in 1974) or now. Certainly, your dispatching personnel, despite their present concerns, will find the Roy case shocking. And certainly, with their recent training and the excellent protocols they have to work from, they shouldn’t be worried about themselves directing a caller to commit such a disastrous act.

As I mentioned in our phone conversation, I personally feel that the highly successful “medical self-help” program introduced by the Phoenix Fire Department may have started a process which will redefine a municipality’s duty to its citizens. Similarly, the “Emergency Medical Dispatch Priority Card System” created by Dr. Jeff Clawson in association with the Salt Lake City Fire Department, may have further advanced the municipality’s duty. In other words, I can foresee a day when a citizen might allege that the municipality (which maintains a full-time public safety dispatching service) was negligent for failing to implement and operate such a service.

Professors Prosser and Keeton, in their book on “The Law of Torts,” stated in regards to the issue of duty that “Changing social conditions lead constantly to the recognition of new duties. No better general statement can be made, than that the courts will find a duty where, in general, reasonable men should recognize it and agree that it exists” (p. 359). Since the Dispatch Priority Card System first gained national visibility (JEMS, vol. 6, No. 2, February, 1981), numerous municipalities have inquired about the article and the Salt Lake City system it describes. It is apparent that this additional measure of life-saving service will become more prevalent (“changing social conditions”), thus leading to the recognition of a new duty upon municipalities to implement the service where feasible. Though there may have been no initial duty for a municipality to provide rescue and emergency medical services to its residents, it assumes certain duties when it offers those services to the public. To the extent that adjectival advisory and/or life-saving services become widespread or prevalent among American municipalities, such services may constitute a new standard to which all similar municipalities (those with full-time public safety dispatching services) will be held.

The point is, while your dispatching personnel express anxiety over the possibility of liability for providing such a service, we may very soon see the day when a municipality faces allegations of negligence for not providing such a service. In view of the fact that implementation of this new level of service does not constitute a major expenditure to the municipality—and thus is basically an organizational/management/training issue, rather than a funding/taxation issue—I feel the case for a legal obligation (duty) to provide it becomes stronger.

With regard to your second question, I feel we need only to refer to one of the standard definitions of negligence. That is, failure in a particular situation to perform as a “reasonable man” would under the same or similar circumstances. What would a “reasonable man” do under the circumstances described in your question? Obviously, the dispatcher would continue to instruct or aid the first caller to a reasonable conclusion. The alternative would be to “abandon” a patient who is known to be in life-threatening circumstance (discussed later).

The natural sequel to this question is whether the municipality would be negligent for failing to provide sufficient numbers of trained dispatchers to successfully deal with the ultimate contingency (numerous simultaneous alarms). Though it has been some time since I have researched this question, I have found that the courts traditionally have applied the standard of “reasonableness.” That is, a public safety agency cannot be expected to incur the cost of always meeting the demands of extraordinary emergency situations (such as an unusual situation where numerous simultaneous alarms or requests for service are received).

For nearly a century, courts in this country have applied an “emergency rule” which Prosser discusses as follows: “the courts have been compelled to recognize that (a person) who is confronted with an emergency
is not to be held to the same standard of conduct normally applied to one who is in no such situation” (p. 196). Having worked as a dispatcher in a busy urban fire department, I know there are occasional situations where this “emergency rule” would apply.

As we discussed in our phone conversation, “abandonment” has been legally defined as the unilateral termination of a physician-patient relationship by the physician, without the patient’s consent and without giving the patient sufficient opportunity to secure the services of another competent physician. As to whether this responsibility (and potential liability) could attach to agents or surrogates of the physician—such as paramedics, or dispatchers operating under a physician’s protocols—there is no case law (simply because there have been no cases).

In my opinion, wrestling with this question of possible “abandonment” and whether it applies to non-physicians is a waste of time. The denial of service, refusal to accept calls, failure to provide advice, etc. would always be judged as to the “reasonableness” of the action under the circumstances prevailing at the time of the incident in question. Unless you can anticipate that one or more of your employees will act unreasonably, thus subjecting the municipality to liability, I wouldn’t be concerned. If you can anticipate that one or more of your employees will act unreasonably, you have a legal obligation to protect the public from the actions of that employee (through training, discipline, discharge, etc.).

Although you did not pose a question concerning imputed negligence (response superior), it seems an appropriate topic for consideration. That is, if an employee (such as a dispatcher) was negligent in the conduct of her/his duties under your Medical Self-Help Dispatch Program, would the municipality ultimately be responsible for the injured person, and likewise obligated to indemnify the employee for his/her losses (legal expenses, judgment, settlement, etc.)? This question would be answered by Colorado statutes with which I am not familiar.

Finally, my professional opinion. After years of arriving “too late” at the scenes of hundreds of life-threatening emergencies, it is difficult for me to offer a detached and unemotional opinion. Throughout the U.S., we have spent billions of dollars constructing systems to respond to medical emergencies and we have done little to cure the deadly four minute gap at the front of the system. While we race through city traffic to get to the scene, a brain dies for lack of CPR (oxygen). Frankly, I don’t understand how any public safety or health care worker can accept these recurring tragedies without actively seeking a solution to the “response time” problem which proves fatal in so many cases.

More than 20 million Americans have been trained to perform CPR, and it has been estimated that another 80 million are interested in learning the technique. These millions of trained lay rescuers are performing the techniques hundreds (if not thousands) of times throughout the country each day. Yet, in the eight years since the American Heart Association and the American Red Cross endorsed the concept of training the public we haven’t heard of a single lawsuit (successful or unsuccessful) against a trained CPR rescuer who performed the technique on a person who needed it.

The statistical proof as to the effectiveness of bystander-initiated CPR is beyond question. As greater numbers of fire and police departments initiate “first responder” programs—to get professional rescuers to the scene as quickly as possible—we can expect the survival statistics to climb. And, finally, communities such as Aurora are beginning to fill the deadly four-minute gap by providing invaluable medical self-help instruction via telephone.

I have personally witnessed the innovative Phoenix “Lifeline” system—and it is saving lives! I have investigated the Salt Lake City program and I feel it is a natural evolution of the Phoenix concept. In my opinion, your City is to be commended for your quick but thorough adaptation of this important service.

In summary, I suppose the concerns which have been expressed over supposed legal hazards are little more than a “red herring” issue. Of greater concern to me is the collective attitude which places such unwarranted fears on a higher plane than the compulsion for human service—especially saving lives.
In 1975, I wrote a book entitled, Emergency Medical Services for Fire Departments (National Fire Protection Assn.). In it, largely based on my own experience as a dispatcher and supervisor of dispatchers, I included the following:

One effective method of obtaining understanding and cooperation from dispatching personnel is to allow them to spend a tour of duty as an observer on an EMS unit. Long periods of time confined to a switchboard tend to deprive the dispatcher—communicator of perspective of field problems. Nothing can cure this common problem faster than a period of first-hand observation of the real world at its worst.

I suspect your problem may be one of narrow perspective, rather than legal hazards.

I apologize for the length of this response. I feel that your undertaking is very important and must not be sidetracked by unrealistic anxiety. As you know, our organization is funded by several leading pharmaceutical companies, and we are pleased to be able to assist you as part of your program of public service. If additional questions occur, I hope you will feel free to call on us again.

Sincerely,

James O. Page, J.D.
Executive Director
The ACT Foundation

Note: Letter used with the permission of James O. Page, J.D.