

In dubio pro REA: criminal liability risks in resuscitation

Marc Thommen

Chair for Criminal Law and Criminal Procedure, Faculty of Law, University of Zurich, Switzerland

Summary

Can lifesaving be punishable? Performing resuscitation in an emergency places individuals under great pressure. Empirical studies indicate that potential helpers often hesitate to intervene for fear of legal consequences. However, this concern is unfounded. The article examines four scenarios: death despite resuscitation, harmful or unwanted resuscitation, and omission of aid. The conclusion is unequivocal: in case of doubt, initiating resuscitation ("in dubio pro REA") is legally safe. Only in cases where it is clearly established that resuscitation is not desired does the exception apply, meaning that no assistance should be rendered ("no means no"). This article analyses criminal liability risks in resuscitation based on Swiss law. Nevertheless, the findings are broadly transferable to other jurisdictions, as the relevant offences are universally codified.

Introduction

Basic life support (BLS) measures and the use of automated external defibrillators (AEDs) are key elements of a successful rescue chain in cardiac arrest cases.¹ However, empirical studies on cardiopulmonary resuscitation (CPR) also indicate that one of the greatest deterrents for potential helpers is their fear of legal consequences.² This is evidenced by persistent claims on social media that resuscitation attempts have led to charges of sexual harassment.³

This article analyses criminal liability risks in resuscitation based on Swiss law. Nevertheless, the findings are broadly transferable to other jurisdictions, as the relevant offences (e.g., intentional or negligent homicide, bodily harm, omissions, coercion) are universally codified. The medico-legal principles discussed likewise reflect internationally recognised standards, including those embedded in the Oviedo Convention on Human Rights and Biomedicine.

The risks of criminal liability in resuscitation are analysed below,⁴ with four scenarios distinguished: What if resuscitation is unsuccessful and the person dies despite resuscitation (death despite resuscitation)? What if the person survives but suffers damage (harmful resuscitation)? What if the person survives but did not want to be resuscitated (unwanted resuscitation)? What if the helper decides not to resuscitate (failure to resuscitate)?

The conclusion may already be anticipated since the risks of criminal liability are negligible provided that helpers adhere to two simple guidelines: first, the rule is that in case

of doubt, resuscitation should be performed (*in dubio pro REA*). Second, the exception to this is that resuscitation must not be performed if it is expressly refused (no means no).

Death despite resuscitation

If a patient dies despite resuscitation, the question arises as to whether this will have criminal consequences. According to Art. 111 of the Swiss Criminal Code,⁵ anyone who *intentionally* kills a person shall be punished with a custodial sentence of no less than 5 years. Rescuers want to save lives, not take them. They do not accept killing, let alone strive for it (Art. 12 para. 2 SCC). Therefore, negligent homicide is going to be the main focus in such cases. For the rescuer to be accused of a breach of duty of care, they must have violated a standard of care and acted in a culpable manner according to the care that is incumbent on them in the circumstances and commensurate with their personal capabilities. Finally, the death must have been foreseeable.

Negligent homicide

According to Art. 117 SCC, anyone who negligently causes the death of a person shall be punished with imprisonment of up to 3 years or a fine. According to Art. 12 para. 3 SCC, anyone who fails to consider the consequences of their conduct due to a culpable lack of care commits a felony or misdemeanor through negligence. A lack of care is subject to liability if the perpetrator fails to exercise the caution required by the circumstances and their personal capabilities.⁶

According to the Swiss Federal Supreme Court, a conviction for negligent homicide first requires that the perpetrator caused the outcome,⁷ which is referred to as causation. According to case law, conduct is causal if it cannot be disregarded without the result also being eliminated; however, this conduct need not be the sole or direct cause of the outcome.⁸ An interesting situation arises in cases involving the death of a patient following an attempt to administer resuscitation. On the issue of causation, the death would not have occurred in the specific time or place that it did but for the attempt at resuscitation. Nonetheless, the helper would obviously not be considered liable because they were attempting to save the patient's life.

Prof. Dr. iur. Marc Thommen
Lehrstuhl für Strafrecht,
Strafprozessrecht,
Wirtschafts- und Verwaltungsstrafrecht
Rechtswissenschaftliche Fakultät
Universität Zürich
Treichlerstrasse 10
CH-8032 Zürich
marc.thommen[at]ius.uzh.ch

Standard of care

The starting point for all duties of care is the prohibition of endangering the protected legal interests of others.⁹ Where specific legal provisions serving the purpose of accident prevention and safety (e.g. road traffic regulations) require certain behaviour, the duty of care is determined by these provisions.¹⁰ In the absence of such standards, reference can be made to generally accepted rules of conduct issued by private organisations¹¹ (e.g. the FIS rules for skiers) or to the principle of danger prevention (“*Gefahrensatz*”).¹²

Standards of care are guidelines for action that have been developed from “painful experience”.¹³ In a medical context, these guidelines are derived from the rules of medical practice (*lex artis*).¹⁴ The guiding principle is the “state of the art” (i.e. the current state of science and doctrine).¹⁵ To determine *whether* resuscitation should be performed, the guidelines published by the Swiss Academy of Medical Sciences (SAMS) “[Decisions on cardiopulmonary resuscitation](#)” would likely be consulted.¹⁶ To determine *how* resuscitation should be performed, the established “best practices” of rescue and emergency medicine and intensive care medicine would have to be identified. For example, the guidelines of the European Resuscitation Council state that the duty of first responders is “*to recognise cardiac arrest, immediately start CPR, call for help and facilitate rapid defibrillation.*”¹⁷ If, after determining that cardiac arrest has occurred, a first responder were to wait 5 minutes before starting resuscitation, they would be violating the aforementioned standard of care in emergency medicine. In its Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, the American Heart Association recommends the following: “*During manual CPR, rescuers should perform chest compressions to a depth of at least 2 inches, or 5 cm, for an average adult [...]. It is reasonable for rescuers to perform chest compressions at a rate of 100 to 120/min.*”¹⁸ Thus, CPR that is too weak or performed at too low a frequency could constitute a violation of the rules. The Swiss Resuscitation Council stipulates that the patient must lie flat on a hard surface for CPR and that the pressure point is in the middle of the chest on the lower half of the sternum.¹⁹ In this case, incorrect positioning or a pressure point that is too low or too high could constitute a breach of the duty of care.

Individual standard of care

The fact that an action violates a standard of care is a necessary but insufficient condition for criminal negligence on its own. The objective violation of a duty of care must also be subjectively attributable to the helper.²⁰ Notably, this concerns the *standard of care* which is determined on an individual basis.²¹ According to [Art. 12 para. 3 sentence 2 SCC](#), in this context, carelessness will constitute a breach of one's duty of care only if the person fails to exercise the caution required by the circumstances and their personal capabilities.

The *personal capabilities* to be considered include the person's education and professional experience.²² The *circumstances* to be considered depend on the type of procedure or treatment, the associated risks, the scope for assessment and evaluation available to the person, and the means and urgency of the medical care. Physicians only violate their

duty of care if they make a diagnosis or choose a therapy that no longer appears reasonable according to the general state of professional knowledge.²³

Regarding the *personal capabilities* of the helpers, it should be noted that lower requirements apply to “normal” doctors than to specially trained emergency doctors and paramedics. Lower requirements would also apply to first responders and, even more so, to laypeople, since their training and practical experience are not comparable to those of medical professionals. Regarding the *circumstances*, behaviour must be assessed from an *ex ante* perspective. In retrospect, no excessive demands may be placed on the responders. Considering the information only available in hindsight would fail to do justice to the extreme circumstances and pressure under which they acted. Therefore, liability would not arise merely because better options had been identified in retrospect; instead, it would only arise if the responder's intervention could be considered obviously unreasonable.²⁴

Predictability

A breach of the duty of care is only subject to liability if the outcome was foreseeable to the person “according to the ordinary course of events and the general experience of life”.^{25,26} Predictability must also be assessed from an *ex ante* perspective and subjectively measured against the standard of care outlined above. Therefore, the question is: “What should the perpetrator have been able to recognise at the time of the act based on the circumstances and his knowledge and abilities?”²⁷ Returning to the above example, it must also be clear to first responders that they are endangering the life of the person concerned if they wait 5 minutes before starting resuscitation.

If the patient dies despite resuscitation, the rescuer who acts to the best of their knowledge and ability is not liable for negligent homicide, even if it later turns out that the rescuer could have taken more effective steps to resuscitate.

Harmful resuscitation

What are the criminal consequences of successful resuscitation? At first glance, this question may seem surprising, especially since a person's life is being saved. First, it should be clarified that BLS measures do not constitute sexual acts under criminal law. Although the chest and mouth may be touched during chest compressions and ventilations, respectively, these actions lack any objective sexual character.²⁸ Accordingly, a helper will not be held criminally liable for sexual offences when performing a resuscitation. Chest compressions performed as part of CPR frequently result in rib fractures.²⁹ Even after successful resuscitation, short-term physical complications such as hypoxia-related organ damage and long-term neurological and psychological impairments can occur. Such injuries are objectively classified as bodily harm (1.). While intent or negligence may be subjectively present (2.), the decisive factor in determining criminal consequences is whether and how these injuries can be justified (3.).

Injury

In the *objective elements of the offence*, assault offences are graded according to the severity of the consequences of the offence. Life-threatening (e.g. ruptured spleen)³¹ and permanent injuries (e.g. from complicated bone fractures)³² are considered serious bodily harm (Art. 122 SCC – serious assault). On the other hand, impairments involving the temporary disturbance of health (e.g. simple bone fractures, concussions)³³ are considered simple bodily harm (Art. 123 SCC – common assault). Additionally, acts of aggression are actions that do not result in damage to the body or health (e.g. slapping; Art. 126 SCC – acts of aggression).³⁴

Chest compressions are likely to reach the threshold of an act of aggression, while broken ribs are generally classified as a simple bodily injury. In the case of lung lacerations or pneumothorax, an expert opinion would be required to determine whether there was a risk to life. Hypoxic brain damage is considered serious bodily injury if it leads to permanent impairment. Overall, damage caused by resuscitation is also considered bodily harm if it is medically *indicated* as a life-saving measure.³⁵ Ultimately, the (therapeutic) end does not justify all (treatment) means.

Intent and negligence

In the *subjective elements of the offence*, intent and negligence must be distinguished from one another. Each can be divided into a knowledge component and a volitional component. A perpetrator acting with intent *knows* that their actions will lead to a specific injury and also *wants* this outcome to occur (Art. 12 para. 2 sentence 1 SCC). A person who acts with conditional intent (“*dolus eventualis*”) considers the outcome *to be possible* based on their knowledge and *accepts* it in terms of volition (Art. 12 para. 2 sentence 2 SCC). A perpetrator who acts with conscious negligence has the same perception in terms of knowledge.³⁶ They consider the outcome *to be possible*. On the volitional side, *they trust that it will not occur*. Perpetrators who act with unconscious negligence lack any awareness of risk; they do not *consider* the outcome (Art. 12 para. 3 SCC).³⁷

In the case of damage caused by resuscitation, the rescuer's perception must be analysed. This can be illustrated by the example of broken ribs. Paramedics and first responders *know* that chest compressions during cardiac massage often cause broken ribs. Even if they *do not want* these fractures *to occur*, they *accept* them for the greater objective of preventing death. Therefore, paramedics and first responders generally act with conditional intent when it comes to such rib fractures. If laypeople are not aware that rib fractures may occur during chest compressions, they are acting with unconscious negligence. In the case of the most serious consequences of resuscitation (hypoxic brain damage), it would have to be argued in practice that trained helpers consider this risk to be possible but trust that this damage will not occur. In this respect, there would be conscious negligence.

Justification

How can these bodily injuries be justified?³⁸ The most prominent justification for medical interventions is the consent of a competent patient (Art. 5 Convention on Hu-

man Rights and Biomedicine³⁹).⁴⁰ Since the patient is not competent in the event of cardiac arrest, it is not possible to obtain informed consent at this point.⁴¹ Therefore, reliance must be placed on their presumed consent.⁴² According to Art. 379 of the Swiss Civil Code⁴³ “[i]n urgent cases, the doctor may carry out medical procedures according to the presumed wishes and interests of the person lacking capacity of judgement.” In the first instance, the *subjective* wishes of the patient shall be considered, and in the second instance, the *objective* requirements.

How the person concerned would have subjectively decided⁴⁴ can be determined from a patient decree. According to Art. 370 CC, a patient decree can specify which medical procedures are to be consented to in the event of incapacity. The patient's wishes may also be evident from a documented REA status.⁴⁵ In the absence of a written document, previously expressed wishes shall be considered.⁴⁶ Relatives or medical staff may provide information about the wishes of the person concerned.⁴⁷ If neither relatives nor medical staff can be consulted, the *objectively* necessary measures may be taken in an emergency (Art. 379 CC; Art. 8 Convention on Human Rights and Biomedicine).⁴⁸ In such cases, there are no indications of what the person subjectively wanted; instead, the justification is based on “necessity” (Art. 17 SCC): the helper is justified because they are preserving life at the expense of bodily integrity.⁴⁹

For example, objectively necessary measures⁵⁰ are set out in the guidelines of the European Resuscitation Council.⁵¹ As a rule, the objectively necessary measure – especially for laypeople and first responders – will be to perform resuscitation regardless of whether injuries to the person may be sustained.⁵² In exceptional cases, such as when resuscitation is futile, it may be objectively necessary to refrain from attempting it.⁵³ In this respect, the person intervening also has a margin of discretion.⁵⁴

In summary, injuries caused by the act of resuscitation are justified either subjectively by presumed consent or, in an emergency, objectively by the fact that life is saved at the expense of bodily integrity.⁵⁵

Unwanted resuscitation

What are the criminal consequences if a person who does not want to be resuscitated is resuscitated? Refusal of resuscitation may be explicitly communicated by a “do not resuscitate” (DNR) order (“REA status: No”), a written advance directive, a verbal statement by the patient, or (rarely) by a “no-CPR” stamp or tag.⁵⁶ Here, it must be assessed which criminal offences apply (1.), whether there is justification (2.) and what applies if the rescuer is unsure whether resuscitation is wanted or not (3.).

Assault and coercion

As set out in Chapter “Harmful resuscitation”, chest compressions constitute direct physical contact at the level of acts of aggression (Art. 126 SCC). Additionally, simple bodily injury (Art. 123 SCC), such as broken ribs or lung lacerations, may occur as a result of compressions. Indirectly, however, serious bodily injury (Art. 122 SCC) in the form of permanent neurological damage may also occur.⁵⁷ The risk of such indirect consequences may be one reason why resuscitation is refused.⁵⁸ Criminal liability

may also arise in the case of unwanted resuscitation, when life-saving measures are taken against the will of the person concerned.⁵⁹ This might constitute coercion if the person concerned is forced to undergo previously refused rescue measures. However, according to the Federal Supreme Court, [Art. 181 SCC](#) protects (only) the freedom to form and exercise one's will.⁶⁰ When viewed in this manner, this provision does not confer a criminally enforceable right to have a previously expressed will respected. Therefore, an unconscious person cannot be coerced into anything.⁶¹ A counterargument could be that the individual is compelled to continue living beyond their state of unconsciousness, despite having expressly rejected this outcome.

Justification

The situations discussed above involving “harmful” resuscitation and the “unwanted” resuscitation discussed here have a common thread: in both cases, there is an *objectively* life-threatening emergency. *Subjectively*, the persons concerned in the first situation agree to the life-saving measures, even if these are accompanied by damage. In this second situation, an objectively necessary life-saving measure is subjectively rejected because it may be accompanied by serious damage.

Presumed consent is ruled out if it is clear from a patient decree, a “do not resuscitate” (DNR) order or previously expressed wishes that the person concerned rejects resuscitation. By means of this refusal, the person concerned establishes a treatment veto, the violation of which constitutes a criminal offence.⁶² In this context, resuscitation also cannot be justified by the fact that assistance may save the life of the person concerned. At first glance, the first responder may appear to be protecting overriding interests by saving life at the expense of physical integrity (broken ribs, etc.). However, this does not constitute justification. No patient must be subjected to rescue against their will, even if their refusal may inevitably lead to death.⁶³

Error

So far, it has been assumed that rescuers are clearly aware when resuscitation is refused (e.g. due to a “do not resuscitate” [DNR] status). However, in many cases, it is unclear whether resuscitation is desired; for example, because a patient's decree cannot be consulted in an emergency. In such cases, the rescuer's assumption is decisive. If they assume that the person would presumably consent to rescue, they are to be judged according to this assumption, even if a DNR status is discovered afterwards ([Art. 13 para. 1 SCC](#)). In the case of *an error as to the justifying circumstances*, the perpetrator mistakenly assumes that the actual conditions for a justification exist.⁶⁴ As such, they must be judged according to this assumption and are thus justified and protected from liability.⁶⁵ Only if the error could have been avoided with due care ([Art. 13 para. 2 SCC](#)) is there a risk of punishment for negligent bodily injury ([Art. 125 SCC](#)). Here, too, avoidability must not be affirmed lightly through an *ex post* assessment, but must rather be assessed *ex ante* in terms of what the rescuers should have recognised during the emergency.

An important example of a situation in which it is often unclear whether life-saving measures are desired or not is

attempted suicide. Should a person who has attempted to take their own life be helped,⁶⁶ or can they be left to die? On the one hand, it is clear that it is not permissible to rescue a suicidal person against their will.⁶⁷ However, an alternative conclusion also follows from this, namely, that if the person is not acting of their own free will, there is a duty to rescue them.⁶⁸ It is not usually possible to determine whether a person is committing a voluntary “calculated suicide” or an involuntary “impulsive” or “appeal suicide”.^{69,70} Therefore, the decisive factor in such cases is what the rescuers imagine: *“In the case of cardiac arrest due to attempted suicide, it should not generally be concluded – purely on the basis of the possible suicidal act – that the person concerned would refuse CPR [...] In doubtful cases, CPR should be attempted (unless the prognosis is wholly unfavourable) [...] If, however, based on the evaluation of the particular case, the medical professional [...] concludes that the person attempting suicide would refuse such assistance, then he or she may withhold or terminate CPR.”*⁷¹

Failure to resuscitate

Can a helper be prosecuted for not resuscitating? Is this a case of failure to provide emergency assistance (1.) or even homicide by omission (2.)? What if the helpers are mistaken about their duty to help (3.)?

Failure to provide emergency assistance

According to [Art. 128 SCC](#), anyone who fails to help a person in immediate danger of death, even though they could reasonably be expected to do so under the circumstances, is guilty of failure to offer aid in an emergency. According to the Federal Supreme Court, the helper must, in principle, “do everything in their power.” The duty to help only ceases to apply when the help no longer meets a need; in particular, if the person expressly refuses the help offered or if death has occurred.⁷² Help is unreasonable if the helper would have to expose themselves to a high risk of accident or infection.⁷³

An immediate mortal danger to life exists when life is hanging by a thread.⁷⁴ Notably, people who suffer a cardiac arrest are in mortal danger.⁷⁵ If a person is in mortal danger, *everyone* is obliged to help,⁷⁶ not only trained professionals. According to the law (*“failure to offer aid”*), only those who do not provide any assistance can be punished. Therefore, only the failure to perform CPR (*“withholding... CPR”*) can be prosecuted, not the discontinuation of CPR (*“withdrawing CPR”*).⁷⁷ Concerning the duty to assist under [Art. 128 SCC](#), a distinction must be made between four scenarios:

Resuscitation required and desired

If resuscitation is *required* and *desired*, there is an obligation under criminal law to provide assistance under [Art. 128 SCC](#).

Resuscitation not required but desired

Do rescuers have to resuscitate a 96-year-old woman with multiple morbidities to avoid criminal liability? First and foremost, this depends on her *wishes*: if it is clear that she wants resuscitation and is willing to accept not only the

possible injuries (broken ribs, etc.) but also possible long-term consequences, failure to resuscitate cannot be justified by these accepted consequences. Often, it will not be clear that resuscitation is desired at any cost, but only that it would presumably be agreed to.

According to the SAMS, resuscitation should be *withheld* if it would offer “no likelihood of benefit”, if there are “signs of certain death” or if there is a risk of “brain death or an extremely poor neurological outcome”.⁷⁸ According to European guidelines, resuscitation may be withheld if “the safety of the provider cannot be adequately assured” or «when there is obvious mortal injury or irreversible death”, or in cases of “severe chronic co-morbidity, very poor quality of life prior to cardiac arrest.”⁷⁹

First, it is clear that there can be no legal obligation to resuscitate (brain-)dead persons. It is also clearly unreasonable to expect helpers to put themselves at risk. In cases where there is no hope of success, regardless of the consent of the person concerned, the fact that no one can be obliged under penalty of law to take objectively futile measures suggests there is no obligation to resuscitate.⁸⁰ The Federal Supreme Court also waives this obligation “if the assistance clearly no longer meets a need”. In medical law, it has long been generally accepted that doctors cannot be obliged to perform interventions that they consider pointless or inappropriate.⁸² Therefore, such an intervention cannot be enforced under penalty of law.

Resuscitation required but not wanted

In the case of unwanted resuscitation, it was explained that a helper who “successfully” resuscitates a person who does not want to be resuscitated may be liable for assault, bodily harm and, if applicable, coercion. Conversely, this means that a helper respecting the wishes of a person who does not want to be resuscitated cannot be held criminally responsible. If the assistance itself constitutes a criminal offence, refraining from providing it cannot be a criminal offence.⁸³

Resuscitation neither required nor desired

Cases in which resuscitation is neither required nor desired are also clear. Here, refraining from resuscitation is not only not punishable, but is in fact required.

Homicide by omission

If resuscitation is omitted, the person concerned dies. This raises the following question: Are helpers who do not perform the required and desired resuscitation only punishable for failure to render emergency assistance under Art. 128 SCC, or also for homicide by omission under Art. 111 SCC?⁸⁴ This question is relevant because failure to provide emergency assistance is a *misdemeanour* (Art. 10 para. 3 SCC) punishable by imprisonment of up to 3 years, whereas homicide is a *felony* (Art. 10 para. 2 SCC) punishable by imprisonment of up to 20 years.⁸⁵

Intentional homicide⁸⁶ under Art. 111 SCC can be committed not only through active actions, but also through passive inaction.⁸⁷ According to Art. 11 SCC a felony or misdemeanour may also be committed through a failure to comply with a duty to act (para. 1). A person fails to comply with a duty to act if they do not prevent an injury de-

spite being obliged to do so by virtue of their legal position (para. 2). Persons who hold such a legal position are called *guarantors*. A guarantor position may arise from statute (lit. a) or from contract (lit. b). For example, parents have a statutory duty as guarantors to protect their child (Art. 302 CC). Parents who fail to rescue their drowning child are not only guilty of failure to render assistance (Art. 128 SCC), but also of homicide by omission (Art. 11 and Art. 111 SCC).⁸⁸

Therefore, helpers are liable for homicide (or at least manslaughter: Art. 113 SCC) by omission if they are in the position of a guarantor. A guarantor is someone who has a *qualified* legal obligation to protect a specific legal interest.⁸⁹ General statutory duties to provide assistance, such as Art. 128 SCC⁹⁰ or § 17 (1) (a) of the Zurich Health Act,⁹¹ according to which “doctors are obliged to provide assistance in urgent cases”, do not establish a guarantor position.⁹²

As a rule, relatives have a legal duty to provide assistance, such as parents for their children (Art. 302 para. 1 CC) and children for their parents and siblings, at least as long as they still live together (Art. 272 CC). The same applies to spouses (Art. 159 para. 3 CC). If they do not at least call the emergency services, they may be liable to prosecution for homicide or manslaughter by omission.

It is recognised that doctors working in emergency or rescue services have a (usually contractual⁹³) duty to render assistance.⁹⁴ The same applies to paramedics.⁹⁵ However, it remains unclear whether first responders also hold a guarantor duty to provide assistance. At first glance, the existence of a guarantor position seems plausible, since they, like professional rescue personnel, are alerted in emergencies and sent directly to the site of the incident. In this respect, an expectation to provide assistance may arise. Guidelines stipulating that “once a call for rescue has been accepted, there is a duty to respond” may also suggest the existence of a guarantor position.⁹⁶ On the other hand, the fact that “not every legal obligation, but only a qualified legal obligation”,⁹⁷ such as that which parents have towards their children, leads to a duty to provide assistance is an argument against this notion.⁹⁸ Such a qualified “duty of care”⁹⁹ is only held, if at all, by contractually bound, professional and remunerated paramedics and doctors, but not by first responders who offer their assistance voluntarily. Otherwise, first responders would be burdened with criminal liability risks on top of their voluntary service. Therefore, a guarantor position for first responders should be rejected. This applies all the more to bystanders who happen to be present and have no connection whatsoever to the person concerned. As such, first responders and third parties can only be prosecuted for failure to provide emergency assistance, but not for homicide by omission.

Error

Omissions can also be based on misjudgments. A distinction must be made between errors of fact (a.), errors as to the justifying circumstances (b.) and errors of law (c.).

Error of fact

An error of fact occurs when a helper does not resuscitate because they fail to recognise that there is a danger to

life or because they believe that resuscitation is futile. If they misjudge the situation in factual terms, they are to be treated according to their perception (Art. 13 para. 1 SCC). If the helper could have avoided the error by exercising due care, they are liable for negligence if the negligent commission of the act is punishable by law (para. 2). The last half-sentence is the most important: failure to provide emergency assistance under Art. 128 SCC is not punishable if committed negligently.¹⁰⁰ This implies that helpers cannot be prosecuted under Art. 128 SCC, even if they grossly misjudge the danger to life or chances of rescue. This applies to all helpers (i.e., doctors, paramedics, first responders and laypeople).

In the case of homicide by omission (Art. 11 and Art. 111 SCC), negligent (c)omission of the act is punishable under Art. 117 SCC. However, only helpers in a guarantor position (i.e. *emergency doctors* and *paramedics*, but not *first responders*) can be prosecuted for this. Here, too, an *ex ante* perspective must be taken,¹⁰¹ which is why only obvious misjudgments can lead to liability.

Error of justification

Such an error would exist if helpers did not intervene because they believed that resuscitation would be refused; for instance, they assume that the person affected has rejected resuscitation, but in reality, the person affected would have wanted to be saved.

Objectively, this constitutes at least a failure to provide emergency assistance (Art. 128 SCC). *Subjectively*, there is intent since the helpers consciously decide not to resuscitate. The failure to provide assistance is *objectively* not justified because resuscitation was necessary and desired. *Subjectively*, however, the helpers make an *error regarding the justification*. They are to be judged according to their perception (Art. 13 para. 1 SCC): They imagined a DNR status. If this perception had been correct, failure to provide assistance would not only have been justified, but withholding CPR would have been warranted. In such instances, an acquittal would have to be granted.

Error of law

46 A third error may involve helpers not being aware that they must help. In this case, they are not mistaken about the facts, but about a legal requirement.¹⁰² Anyone who, when committing the act, does not know and cannot know that they are acting unlawfully does not act in a culpable manner. If the error was avoidable, the court will reduce the sentence (Art. 21 SCC). Ignorance (“*does not know*”) of a requirement or prohibition thus protects *de jure* against punishment. However, this only applies if this ignorance was unavoidable (“*cannot know*”). Federal Supreme Court case law on unavoidability under Art. 21 SCC is so strict that, *de facto*, the old legal aphorism “*error iuris nocet*” (i.e. ignorance of law is no defence),¹⁰³ continues to apply. Such an error of law is already excluded “if the perpetrator has the vague feeling that they are doing something wrong. The perpetrator does not need to know the exact legal classification of their behaviour.”¹⁰⁴ An error of law is only unavoidable if “even a conscientious person would have been misled.”¹⁰⁵ Those subject to the law should endeavour to familiarise themselves with it.¹⁰⁶

Even those who are not familiar with Art. 128 SCC cannot claim ignorance of the law, because conscientious people must be aware of their general duty to render assistance.¹⁰⁷

Guidelines

In summary, the risk of criminal liability for helpers is very low. Incorrect resuscitation can lead to liability for negligent bodily injury or homicide. Resuscitation performed against the will of the patient can result in liability for bodily injury or coercion. Anyone who fails to perform necessary and desired resuscitation may be liable for failure to render emergency assistance.

However, in all cases, the incorrect performance of the resuscitation or the misjudgment of the desire for resuscitation must have been clearly recognisable *ex ante*, taking into account the pressure and stress of the emergency situation. Examples would include resuscitation that is only started after a waiting period of 5 minutes, a deliberately disregarded “do not resuscitate” (DNR) order or, in the case of omission, a conscious disregard of the patient's desire for resuscitation (REA status: Yes).

In practice, guidelines are needed that are, firstly, understandable to laypeople and, secondly, easy to access even under great pressure. Two sets of guidelines are presented below, which are related to each other as a rule (1.) and an exception (2.).

Rule: In dubio pro REA

The first guideline is: “*In dubio pro REA*” (when in doubt, resuscitate).¹⁰⁸ This is a play on words derived from the legal maxim “*in dubio pro reo*” (when in doubt, rule in favour of the accused).¹⁰⁹ The starting point of this rule is to consider the *standard cases* in which resuscitation is objectively necessary and presumably desired. In such situations, providing assistance is not only morally imperative, but also legally mandatory: anyone who fails to help a person in mortal danger, when this could reasonably be expected of them under the circumstances, is guilty of at least failing to render assistance under Art. 128 SCC.¹¹⁰

As its wording (“*in dubio*”) suggests, the rule also covers *cases of doubt* in which resuscitation is objectively necessary but where it is unclear whether the person concerned would consent to or refuse resuscitation. In such situations, there is double protection.

1. *The error rule* (Art. 13 SCC): First responders who assume in good faith that resuscitation is desired by the person concerned will be judged according to their assumption, even if it later turns out that they were mistaken.
2. *The emergency rule* (Art. 379 CC): In emergencies, it will often be unclear whether resuscitation is desired by the person concerned. This may be because there is no advance directive, a patient decree is not available on short notice, the resuscitation status is unknown, or relatives are not present or unable to provide reliable information. If first responders cannot determine the subjective will of the person concerned in such situations, they will also be legally protected if they perform an objectively necessary resuscitation. In summary, they will be legally protected in performing a resuscitation because they are attempting to save a life.

Exception: No means no

Every rule has an exception. If there are clear indications that resuscitation is refused, this wish must be respected. These clear indications may be provided by a negative resuscitation status, an advance directive/patient decree, a credible statement from the person in question conveyed by relatives, or, in rare cases, a “No-CPR” stamp or tag. Where the person concerned has expressed or recorded a clear refusal of resuscitation, assistance must not be provided, even if resuscitation is highly likely to be successful. No means no!

Background to this article

On 24 August 2025, the author submitted a comprehensive legal opinion to the Swiss Resuscitation Council on criminal liability risks for first responders performing basic life support (BLS-AED) [see full PDF of the German Version]. This article aims to share the most important findings from this opinion with a specialist legal and medical audience. The article is also published in German (Thommen M. In dubio pro REA, Strafbarkeitsrisiken bei der Reanimation. *sui generis*. 2025. <https://doi.org/10.21257/sg.283>) and French (Thommen M. In dubio pro REA, Risques de poursuites pénales en matière de réanimation. *sui generis*. 2025. <https://doi.org/10.21257/sg.284>).

Acknowledgments

The author would like to express his sincere thanks to Martina Farag-Jaussi, attorney-at-law and law clerk at the High Court of the Canton of Bern, for her careful revision and review of the original manuscript. The translation of the manuscript into English was performed with the assistance of DeepL Pro and ChatGPT 5.0. The author wishes to express his gratitude to Patricia Soltani, MLaw, attorney-at-law, and Benedict Elliott, LL.B. (Hons), for their meticulous review and correction of the English version of the manuscript.

Financial disclosure

The legal opinion on which this article is based was commissioned and financed by the Swiss Resuscitation Council (SRC).

Potential competing interests

The author has completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. No potential conflict of interest related to the content of this manuscript was disclosed.

Footnotes

- 1 – Jasmeet Soar et al., *European Resuscitation Council (ERC) Guidelines 2021 – Adult advanced life support*, Resuscitation 2021, p. 115 ff. (“[R]ecognise cardiac arrest, immediately start CPR, call for help and facilitate rapid defibrillation.”); Swiss Resuscitation Council, *Kursrichtlinien 2021, Leitfaden für Anbieter von Basic Life Support Kursen*, version of 30. March 2021, p. 20 f. For a graphical overview of the rescue chain, see *Terminology* of the Intervallverband für Rettungswesen (Interassociation for Rescue Services) from May 2014, slide 3 [in German].
- 2 – Simone Savastano / Vincenzo Vanni, *Cardiopulmonary resuscitation in real life: The most frequent fears of lay rescuers*, Resuscitation 2011, p. 569 (“In the case of adult resuscitation, the main fear is generic, followed in order of importance by the fear of causing damage, of being caught up in legal implications, of contracting infectious diseases and lastly of not being able to resuscitate.”).
- 3 – Facebook post on 19. May 2021 (Youneedtoknownews, *Woman press sexual assault charges on a man who performed mouth-to-mouth CPR on her*); Instagram post from @drmerije on 26. July 2025 (Man charged with sexual assault after performing CPR on unconscious woman).

- 4 – For the construction of criminal liability under Swiss Law and a general taxonomy, see Marc Thommen, *Introduction to Swiss Law*, 2nd edition, Zürich 2022, p. 423 ff.
- 5 – Swiss Criminal Code of 21. December 1937 (SCC; SR 311.0).
- 6 – See generally Christopher Geth, *Strafrecht, Allgemeiner Teil*, 7th ed., Basel 2021, N 455 ff.; Marc Thommen / Martina Farag-Jaussi, *Feuer und Flamme für Brandschutzvorschriften – Strafrechtliche Sorgfaltspflichten im Umgang mit Feuergefahren*, *sui generis* 2020, p. 146.
- 7 – Federal Supreme Court judgment: BGE 143 IV 138 consid. 2.1; for case citations in Swiss Law: Marc Thommen, *Introduction to Swiss Law*, 2nd ed., Zürich 2022, p. 20 ff.
- 8 – BGE 125 IV 195 consid. 2b.
- 9 – BGE 134 IV 193 consid. 7.2.
- 10 – Federal Supreme Court, judgment of 6 September 2016 (6B_1049/2015), consid. 2.4.2.
- 11 – Federal Supreme Court, judgment of 3 May 2005 (6P.163/2004), consid. 11.
- 12 – In BGE 126 III 113 consid. 2.a/aa the Federal Supreme Court states that anyone who creates a dangerous situation must take the precautionary measures required by the circumstances to prevent an accident from occurring.
- 13 – Thommen/Farag-Jaussi (n. 6), p. 138.
- 14 – Günter Stratenwerth / Felix Bommer, *Schweizerisches Strafrecht, Allgemeiner Teil I*, 5th ed., Bern 2024, § 16 N 19. For detailed information on the rules of medical practice, see Brigitte Tag, *Der Körperverletzungstatbestand im Spannungsfeld zwischen Patientenautonomie und Lex artis, Eine arztstrafrechtliche Untersuchung*, Habil. Heidelberg 1999, Berlin et al. 2000, § 12 p. 199 ff.
- 15 – Ceteris paribus for veterinary medicine: Alexander Tritthart / Gerhard Aigner, *Die «lex artis» als Sorgfaltsmaßstab tierärztlichen Handelns*, *Wiener Tierärztliche Monatsschrift – Veterinary Medicine Austria* 2016, p. 225 ff.
- 16 – Swiss Academy of Medical Sciences (SAMS), *Medical-ethical guidelines, Decisions on cardiopulmonary resuscitation* approved by the SAMS Senate on 11 June 2021. For consideration of the guidelines in general: Franziska Sprecher, *Gutachten zur Klärung des rechtlichen Rahmens und der Legitimation der medizin-ethischen Richtlinien der SAMW zuhanden Schweizerische Akademie für Medizinische Wissenschaften (SAMW)*, Bern 2024, p. 3 (which states that the SAMS guidelines are considered in case law by both cantonal courts and the Federal Supreme Court.).
- 17 – Soar et al. (n. 1), p. 115 ff.
- 18 – Raina M. Merchant et al., On behalf of the Adult Basic and Advanced Life Support, Pediatric Basic and Advanced Life Support, Neonatal Life Support, Resuscitation Education Science, and Systems of Care Writing Groups, *Part 1: Executive Summary: 2020 American Heart Association, Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care*, *Circulation* 2020.
- 19 – Swiss Resuscitation Council (n. 1), p. 20.
- 20 – On the dispute over whether this culpability pertains to the wrongfulness or the guilt of the act, with further references by Marcel Alexander Niggli / Stefan Maeder, in: Niggli/Wiprächtiger (Hrsg.), *Basler Kommentar, Strafrecht*, 4th ed., Basel 2019, Art. 12 N 101 (cit. BSK StGB-Author), where the authors hold that according to the prevailing view in recent doctrine, the required individualisation always affects the constituent elements of the offence, with the result that a person who could neither recognise nor prevent the risk of the offence occurring is not only exonerated on the grounds of lack of guilt, but does not commit an offence at all.
- 21 – Geth (n. 6), N 468, where the author advocates for a subjective standard according to which an individual’s special knowledge and particular abilities increase their duty of care, while below-average abilities correspondingly reduce it.
- 22 – BGE 97 IV 169 consid. 2.
- 23 – BGE 148 IV 39 consid. 2.3.4.

24 – BSK StGB-Maeder, Art. 128 N 42, where the author maintains that helpers who take all measures that are reasonably apparent and possible to them successfully fulfil their duty, even if it subsequently transpires that other measures would have been more suitable for saving the life that was threatened.

25 – BGE 135 IV 56 consid. 2.1.

26 – Thommen/Farag-Jaussi (n. 6), p. 142, hold that no accusation can be made, beyond what is foreseeable.

27 – BGE 135 IV 56 consid. 2.1.

28 – BGE 125 IV 58 consid. 3b, where sexual acts are considered to be forms of conduct which, in their outward appearance, are clearly sexual in nature from the perspective of an external observer.

29 – Jiri Karasek et al., *CPR related injuries*, European Heart Journal 2020, p. 1827 (“We have analyzed 628 autopsies: 80,4% men, age median 67 years, out of hospital cardiac arrests 89,2%, bystander CPR 56,8% and cardiac ethiology 78,2%. Ribs injury were founded by 94,6%, injury of lung by 9,9%, sternal injury by 62,4%, liver by 2,5% and spleen by 1,8%”).

30 – Reinhard Larsen, *Kardiopulmonale Reanimation*, Anästhesie und Intensivmedizin für die Fachpflege 2016, p. 627 ff.

31 – In BGE 109 IV 18 consid. 2c, the Federal Supreme Court holds that life-threatening bodily injury can only be said to have occurred if the injury led to a condition in which the possibility of death became so likely that it became a serious and urgent probability. This condition was considered met in the cited case because the ruptured spleen could have led to death without immediate surgical intervention.

32 – BGE 105 IV 179 (femoral neck fracture with subsequent total hip replacement).

33 – According to BGE 103 IV 65 consid. II.2.c, this can occur through external or internal injuries and damage, such as uncomplicated bone fractures or concussions, or by blows, impacts and similar causes of bruising, abrasions and scratches, unless these have no further consequences than a temporary, harmless disturbance of well-being.

34 – Federal Supreme Court, judgment of 10 July 2018 (6B_1405/2017), consid. 2.1: It is held that acts of aggression, punishable under Art. 126 SCC, are defined as physical harm that exceeds what is socially tolerated and does not cause bodily injury or damage to health. Examples include slapping.

35 – In BGE 124 IV 258 Regeste, the Federal Supreme Court held that even if they are medically indicated and performed in accordance with best practice, medical interventions fulfil the objective criteria for bodily harm insofar as they either interfere with the physical substance of the body (e.g. in the case of amputations) or at least temporarily impair or worsen the physical performance or physical well-being of the patient to a significant degree.

36 – For terminology on conscious and unconscious negligence, see BSK StGB-Niggli/Maeder, Art. 12 N 85.

37 – Geth (n. 6), N 457; see also the overview by Marc Thommen, *Eventualvorsatz und bewusste Fahrlässigkeit (Länderbericht Schweiz)*, Beitrag anlässlich der 13. Türkischen Strafrechtstage in Ankara, 2018.

38 – For the sake of clarity, only justification in the case of intentional offences will be discussed below. In the case of negligent offences, impunity can be reached in two ways. If a helper considers hypoxic brain damage to be possible but trusts that it will not occur, deliberate negligence may be considered. However, if it is established that, according to the relevant standards of emergency medicine, resuscitation was objectively necessary despite these risks and the helper carried out the resuscitation carefully while considering the specific circumstances and his individual abilities, then there is no breach of the duty of care. Another way of reaching impunity in such situations is that the persons concerned, like the rescuers, trust that the possible damage will not occur, but both are prepared to take the risk, cf. Laura Jetzer, *Einverständliche Fremdgefährdung im Strafrecht*, Diss. Luzern, Luzern et al. 2015, N 271. On the dispute regarding whether justifications for negligent offences should be dealt with at the level of breach of duty of care or only at the level of unlawfulness, see Andreas Donatsch / Gunhild

Godenzi / Brigitte Tag, *Strafrecht I, Verbrechenslehre*, 10th ed., Zurich 2022, p. 349 ff.

39 – European Convention of 4 April 1997 for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (Convention on Human Rights and Biomedicine; SR 0.810.2). See also the Swiss Federal Council's dispatch concerning the European Convention of 4 April 1997 on the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine) and the Additional Protocol of 12 January 1998 on the Prohibition of Cloning Human Beings of 12 September 2001 (BB1 2001 271), p. 291, according to which doctors may not simply do what they believe is right. Instead, patients themselves must decide whether or not they want to undergo a particular examination or treatment. They may refuse treatment even if this damages their health or shortens their life. Valid consent to a medical procedure also requires that the patient has been informed in advance of all essential elements (e.g. the purpose, nature, risks and consequences of the intervention).

40 – In BGE 124 IV 258 consid. 2, the Federal Supreme Court held that even if, in the opinion of the physician, medical interventions are medically indicated and have been performed in accordance with best practice, they still constitute bodily harm. Therefore, such procedures can only be justified with the patient's consent. Already in BGE 99 IV 208 Regeste, it states that any medical treatment that violates physical integrity or health constitutes bodily harm. However, doctors are not at fault if they have acted with the patient's consent.

41 – SAMS Decisions on cardiopulmonary resuscitation (n. 16), p. 7.

42 – BGE 124 IV 258 Regeste states that interventions can be justified by the express or presumed consent of the patient.

43 – Swiss Civil Code of 10 December 1907 (CC; SR 210).

44 – Marc Thommen, *Medizinische Eingriffe an Urteilsunfähigen und die Einwilligung der Vertreter*, Eine strafrechtliche Analyse der stellvertretenden Einwilligung, Diss. Basel 2004, p. 13, stresses the necessity of determining whether the person incapable of judgement would consent to or refuse the intervention if they could be asked.

45 – SAMS Decisions on cardiopulmonary resuscitation (n. 16), p. 22 (“5.4 Documentation of the CPR decision in the patient's records – The CPR decision must be documented, with a brief statement of reasons, in the patient's records. The documentation must include details of when and where the discussion took place and who took part, CPR status (Yes/No), intensive care (Yes/No) and intubation (Yes/No).”).

46 – Under the heading “Previously expressed wishes”, Art. 9 Convention on Human Rights and Biomedicine states: “The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account.”

47 – Thommen (n. 44), p. 14, notes that the intervening doctor in an emergency should be able to determine the current presumed will by looking at the overall picture of previous expressions of will and the general lifestyle of the person now incapable of judgement. He further maintains that to this end, the doctor will have to seek dialogue with relatives and other persons familiar with the person concerned (e.g. the family doctor).

48 – Under the heading “Emergency situation”, Art. 8 Convention on Human Rights and Biomedicine states: “When because of an emergency situation the appropriate consent cannot be obtained, any medically necessary intervention may be carried out immediately for the benefit of the health of the individual concerned.”

49 – Thommen (n. 44), p. 117, maintains that although decisions made by representatives on behalf of persons who were previously capable of judgement must, in principle, be based on the substituted judgement principle, where there are no concrete indications of previous expressions of will, the best interest principle must be applied again and further states (p. 120) that the action of the emergency responder is justified because it helps someone who is in immediate danger and safeguards overriding interests.

50 – Under the heading “Professional standards”, Art. 4 Convention on Human Rights and Biomedicine states: “Any intervention in the health

field, including research, must be carried out in accordance with relevant professional obligations and standards"; see Council of Europe, [Explanatory Report](#) to the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, European Treaty Series (ETS) – No. 164, Oviedo 1997, § 32: "The current state of the art determines the professional standard and skill to be expected of health care professionals in the performance of their work."

51 – Soar et al. (n. 1), p. 115 ff.

52 – This illustrates how the aforementioned "justification" (n. 38) works in cases of negligence: trained rescuers know, or at least consider it possible, that serious hypoxia-related brain damage can occur as a result of resuscitation, but they generally trust that this will not occur. Subjectively, they are therefore acting with conscious negligence; however, they are not guilty of negligent grievous bodily harm ([Art. 125 para. 2 SCC](#)) if it is established that resuscitation was necessary in this situation according to the relevant rules of emergency medicine. In this respect, there is no breach of duty ([Art. 12 para. 3 SCC](#)). The same result (acquittal) can be reached through the so-called *assumption of risk doctrine*: the risk consciously taken by the rescuers is (presumably) approved by the person concerned.

53 – See section "Failure to provide emergency assistance".

54 – Council of Europe (n. 50), § 32: "Nevertheless, it is accepted that professional standards do not necessarily prescribe one line of action as being the only one possible: recognised medical practice may, indeed, allow several possible forms of intervention, thus leaving some freedom of choice as to methods or techniques."

55 – Insofar as negligently inflicted bodily harm is concerned (e.g. hypoxia-induced brain damage), criminal liability is excluded either because there has been no breach of the duty of care, or because a presumed consent to the risk removes the unlawfulness of the consciously accepted danger of injury, see n. 38 and n. 52 above.

56 – [SAMS Decisions on cardiopulmonary resuscitation](#) (n. 16), p. 8 ("Advance directives and instructions for medical emergencies which reject CPR are binding. Credible information from third parties is regarded as valid evidence of the patient's (presumed) wishes. More controversial, however, is the legal weight to be accorded to DNAR symbols of any kind, such as "No CPR" stamps or necklaces. While these do not have the same legal force as an advance directive – lacking a date and signature – they still provide a strong indication of presumed wishes. In such a situation, the emergency medical team may be guided by this evidence of the patient's presumed wishes and withhold CPR.").

57 – For the "outcomes of resuscitation", see the overview in the [SAMS Decisions on cardiopulmonary resuscitation](#) (n. 16), p. 41 ff.

58 – John Saunders, [Who's for CPR?](#), Journal of the Royal College of Physicians of London 1992, p. 255 ("Any competent patient who rationally refuses CPR probably decides on a judgment of the quality of his life.").

59 – See also BSK StGB-Schwarzenegger/Stössel Vor Art. 111 ff. N 51, where the authors argue that the refusal of medically indicated treatment by a quadriplegic or cancer patient who is not [yet] in a state of near death must also be respected by doctors and nursing staff. Otherwise, it would be considered bodily harm or assault.

60 – [BGE 141 IV 437](#) consid. 3.2.1 confirms that the object of protection under [Art. 181 SCC](#) is the freedom of the individual to form and exercise their will.

61 – BSK StGB-Delnon/Rüdy, Art. 181 N 16, where the authors state that victims of unlawful coercion are natural persons who are holders of the protected right to freedom and who are simultaneously capable of forming, deciding or exercising their will. Consequently, an unconscious person cannot be coerced. For Germany: Arndt Sinn, in: Erb/Schäfer (eds.), Münchener Kommentar, Strafgesetzbuch, Band 4, 5th ed., Munich 2025, § 240 N 26 (cit. MüKo StGB IV-Author), where the authors deem it questionable whether the inclusion of sleeping and unconscious persons in the eligible group of victims can be justified.

62 – On the so-called *blocking effects of consent*, see MüKo StGB IV-Erb, § 34 N 38, where the author maintains that where consent is withheld, such a decision must be respected even if it appears objective-

ly unreasonable; for instance, in situations where medically necessary treatment is refused. According to the author, this applies in principle even if the person concerned does not have the full capacity to dispose of the legal interest concerned, so that, for example, even life-saving surgery may not be forced upon the person concerned.

63 – On the criminal liability of an imposed rescue measure, see also Ulfrid Neumann, in: Kindhäuser/Neumann/Paeffgen/Saliger (Hrsg.), Nomos Kommentar StGB, 6th ed., Baden-Baden 2023, Vorbemerkungen zu §§ 211-217 N 86 (cit. NK StGB-Author), where the authors maintain that rescue measures imposed on suicidal persons acting of their own free will may [...] be punishable as coercion [§ 240] or bodily harm [§§ 223 ff., 340].

64 – Marc Thommen / Elmar Habermeyer / Marc Graf, [Tatenlose Massnahmen?](#), sui generis 2020, p. 333.

65 – On the dispute regarding whether an error as to the justifying circumstances leads to justification, see Thommen/Habermeyer/Graf (n. 64), p. 333 N 24, where the authors argue that acting in putative self-defence leads to justification.

66 – On the question of whether this could constitute "Failure to offer aid in an emergency" under [Art. 128 SCC](#), see section "Failure to provide emergency assistance".

67 – Müko StGB IV-Schneider, Vor § 211 N 71.

68 – NK StGB-Neumann, Vorb. §§ 211-217 N 87, where the author holds that insofar as there is no free will to commit suicide, not only active participation but also failure to prevent the act of suicide or to take rescue measures is punishable. The omitting guarantor is to be punished as the perpetrator of a homicide.

69 – Monika Bobbert, [Suizidwunsch und die Perspektiven der Anderen: Zur Problematik impliziter Vorannahmen und der Hilflosigkeit Nahestehender](#), EthikJournal 2/2017, describes that attempted suicide is often an appeal to the community and a desperate cry for attention from fellow human beings (p. 5), noting that the possibility of a calculated suicide as opposed to a spontaneous suicide is usually presumed (p. 18).

70 – Müko StGB IV-Schneider, Vor § 211 N 82, where the author argues that a distinction between suicides that trigger a duty to assist and suicides that permit passivity should not be considered because it is impossible to reliably determine the inner state of mind of a person who is tired of life within the short period of time available for a life-saving decision at the scene of an accident.

71 – [SAMS Decisions on cardiopulmonary resuscitation](#) (n. 16), p. 25.

72 – Federal Supreme Court, judgment of 19 January 2022 ([6B_1109/2020](#)), consid. 2.3.2.

73 – BSK StGB-Maeder, Art. 128 N 44 with reference to N 29, where it is held that [Art. 128 SCC](#) has been subject to the restriction that the perpetrator "could reasonably be expected to provide assistance under the circumstances", and N 31, where it is specified that would be unreasonable if the person obliged to provide assistance would have to expose themselves to a high risk of accident, infection or attack.

74 – In [BGE 121 IV 18](#) consid. 2a, the Federal Supreme Court states that the risk of death would have to appear so imminent that the person's life is hanging by a thread.

75 – In [BGE 121 IV 18](#) consid. 2a, the Federal Supreme Court explicitly specifies that a person suffering a heart attack is considered to be in imminent danger of death.

76 – See [BGE 121 IV 18](#) consid. 2b.aa, where the duty to render aid to a person was confirmed even when a third party arrived at the flat; in such a situation, the obligation to provide assistance was considered to be incumbent on each of them for as long as the danger persisted.

77 – For the distinction: Spyros D. Mentzelopoulos et al., [European Resuscitation Council Guidelines 2021: Ethics of resuscitation and end of life decisions](#), Resuscitation 2021, p. 410 ff. ("Deciding when to start and when to stop cardiopulmonary resuscitation (CPR) – Withholding and Withdrawing CPR.").

78 – [SAMS Decisions on cardiopulmonary resuscitation](#) (n. 16), p. 30 ("6.4. Withholding CPR where it offers little or no likelihood of benefit. In some situations, the initiation of CPR is not indicated or appropriate. This is the case if the patient has rejected CPR, or if there is clear

evidence that it would offer little or no likelihood of benefit. CPR is to be withheld in patients with signs of certain death or with non-survivable injuries. [...] The decision not to initiate CPR should be made by a physician or by a professional with the relevant (medically delegated) authority and, as far as possible, on the basis of consensus among the professionals providing assistance. In emergency medical services, instructions on procedure must be available for non-medical personnel.”); without this reservation: Mentzelopoulos et al. (n. 77), p. 408 ff. (“Unequivocal criteria: When the safety of the provider cannot be adequately assured; When there is obvious mortal injury or irreversible death; [...]. Further criteria to inform decision making: Persistent asystole despite 20 minutes of advanced life support (ALS) in the absence of any reversible cause.”).

79 – On the reasonableness of assistance, BSK StGB-Maeder, Art. 128 N 44 maintains that while it deserves the utmost respect to risk one's own life or even only one's health in order to save another, this cannot be required under penalty of law. Accordingly, the provision is argued to be limited in such a way that, here too, assistance must only be provided within the bounds of what is reasonable.

80 – Saunders (n. 58), p. 256 (“Futility of treatment outcome is another reason for a DNR order: describing a treatment as futile implies its prohibition. The patient is not merely a customer.”).

81 – Federal Supreme Court, judgment of 19 January 2022 (6B_1109/2020), consid. 2.3.2 confirms that the elements of Art. 128 SCC are fulfilled as soon as the perpetrator fails to help the injured person, regardless of whether the help would have been successful. However, the duty to provide assistance ceases to apply if the assistance is clearly no longer needed, particularly if the person expressly refuses the assistance offered or if death has occurred.

82 – Monika Ploier, *Recht des Patienten auf Therapie – Recht des Arztes auf Therapieverweigerung?*, Journal für Neurologie, Neurochirurgie und Psychiatrie 2008, p. 66, where it is maintained that, in principle, a patient who is capable of understanding and making judgements may express a wish to undergo treatment that is not medically indicated. It is then up to the attending physician to decide whether or not to comply with this request for treatment. In such a case, the patient has no enforceable claim, since the attending physician cannot be obliged to perform a medically non-indicated procedure; Isabelle Richter, *Indikation und nicht-indizierte Eingriffe als Gegenstand des Medizinrechts*, Diss. Leipzig 2016, Berlin 2018, p. 509, also states that the patient has no right to the performance of non-indicated medical measures.

83 – Federal Supreme Court, judgment of 19 January 2022 (6B_1109/2020), consid. 2.3.2 states that the duty to render assistance ceases when it is clearly no longer required, particularly where the person expressly refuses the help offered.

84 – For the two forms of criminal liability for omissions, see Annett Weise / Sebastian Koch, *Garantenstellung im Rettungsdienst – Wann kann Nichtstun strafbar sein?*, retten 2020, p. 228 ff.

85 – According to Art. 111 SCC, any person who kills another person intentionally shall be liable to a custodial sentence of not less than 5 years. According to Art. 40 para. 2 sentence 2 SCC, the maximum term of a custodial sentence is 20 years.

86 – For the sake of clarity, only intentional homicide by omission will be discussed below. Strictly speaking, *negligent* homicide by omission should also be discussed; for example, when a person fails to recognise that another person needs resuscitation due to negligent carelessness (unconscious negligence) or when the rescuer recognises the need for resuscitation but mistakenly believes that it will be refused (conscious negligence). However, even in these cases, the question to be addressed immediately would be whether the rescuer is in a position of responsibility at all. The reverse case, where it is recognised that resuscitation is necessary but the rescuer trusts that death can be prevented even without resuscitation, would probably be classified by the Federal Supreme Court as conditional intent (*dolus eventualis*) to kill by omission in view of the imminent danger of death, cf. BGE 130 IV 58 consid. 8.4.

87 – On the criminal liability by omission in general, see BGE 53 I 351 consid. 3a, where the Federal Supreme Court held that not only a person's positive actions but also their omissions are considered criminal-

ly significant behaviour, and omissions give rise to criminal liability if: a) there was a legal obligation to act and b) the inaction was 'causal' for the punishable outcome.

88 – Adrian Dan, *Le délit de commission par omission: éléments de droit suisse et comparé*, Diss. Genf 2014, Genf et al. 2015, N 192.

89 – BGE 141 IV 249 consid. 1.1.

90 – Wolfgang Wohlers, in: Wohlers/Goeden/Schlegel, *Schweizerisches Strafgesetzbuch Handkommentar*, 5th ed., Bern 2024, Art. 11 StGB N 12.

91 – Canton of Zurich Health Act of 2 April 2007 (GesG/ZH; LS 810.1).

92 – Moritz W. Kuhn / Tomas Poledna, *Arztrecht in der Praxis*, 2nd ed., Zurich 2007, p. 719, convincingly argue that the guarantor position in medical criminal law should be reduced teleologically if it is not to be boundless. Thus, the general duty to render assistance under Art. 128 SCC does not establish a guarantor position any more than the general duty of good faith or the professional activity of a physician in general. Rather, what is described as necessary is an increased duty to protect the endangered legal interest or to avert danger.

93 – Kuhn/Poledna (n. 92), p. 719 f., maintains that the treatment contract underlying the doctor-patient relationship generally establishes the doctor's position as guarantor for the life and health of the patient.

94 – Elmar Biermann, *Rechtliche Aspekte in der Notfallmedizin – Teil 2*, Notfallmedizin up2date 2010, p. 27, finds that doctors who are employed in emergency medical services or rescue services under a contract with the National Health Service, or who are responsible for admitting patients to a hospital, have a duty of care (i.e. an obligation to provide medical care to emergency patients).

95 – See German Federal Court of Justice, judgment of 25 April 2001 (BGH I StR 130/01), LG Nürnberg-Fürth, where the Court holds that when the two defendants assumed their protective role as paramedics, they entered into a relationship of care towards the victim, which was essentially determined by the duty to protect [the victim] from further damage to his health.

96 – Canton of Aargau, Department of Health and Social Services, Health Division, *Richtlinien für First Responder im Kanton Aargau*, Aarau 2023, p. 13, is an example of guidelines that clearly set out the first responder's duty to respond once a call has been answered. When first responders receive an alarm, it is at their personal discretion whether to accept the call and thus carry out the operation. Only when the alarm has been accepted is there an obligation to respond.

97 – BGE 141 IV 249 consid. 1.1 affirms that not every legal obligation is sufficient for the assumption of a guarantor position, but only a qualified legal obligation; BGE 134 IV 255 consid. 4.2.1 also confirms that not merely any legal obligation is sufficient, but only that of a guarantor; BGE 120 IV 98 consid. 2c again sets out that the offence can only be committed by omission if the beneficiary has a duty of care. Not merely any duty will suffice, but only a qualified legal obligation.

98 – For more details on qualified legal obligations, see Dan (n. 88), N 190, where it is held that in the case of an omission, such a duty must have several qualities in order to give rise to a position of guarantor. First, it must precisely designate the person on whom it rests. The second quality is the nature of this duty: it must be a legal duty. The third characteristic relates to the content of this duty: it must require action to be taken. The purpose of the required action must be to safeguard a legally protected interest. Only if these conditions are met can we speak of a duty of the guarantor, which is thus a qualified legal duty.

99 – In BGE 141 IV 249 consid. 1.1, the Federal Supreme Court makes a distinction between duties of care (i.e. guarantor positions for the protection of a specific legal interest against all threats to it) and monitoring duties (i.e. guarantor positions for the monitoring of specific sources of danger for the protection of an undetermined number of legal interests).

100 – The general rule of Art. 12 para. 1 SCC applies: “Unless the law expressly provides otherwise, a person is only liable to prosecution for a felony or misdemeanour if they commit it wilfully.”

101 – Regarding the recognisability of risks, the Federal Supreme Court has developed well-established case law. Under the theory of

adequacy, the question of whether an act – according to the ordinary course of events and general life experience – was capable of causing or facilitating a result of the kind that occurred must be assessed *ex ante* (i.e., from the perspective at the time of the act). Subsequent, more accurate knowledge of the causal relationships cannot determine whether the act was lawful or unlawful at the time it was performed; [BGE 135 IV 56](#) consid. 2.2.

102 – On the terminology, see BSK StGB-Niggli/Maeder, Art. 21 N 6, where it is explained that legal doctrine and case law had long adopted the term “error as to prohibition” (*Verbotsirrtum*), which was also used in the Federal Council’s draft. The expression “error as to unlawfulness” was preferred only because it was feared that the proposed marginal heading might be too restrictive, given that in cases of omission, the error as to prohibition becomes an error as to obligation.

103 – For a historical perspective, see Martin Heger, [Geschichte und Gegenwart des Verbotsirrtums im deutschen Strafrecht](#), Jahrbuch der juristischen Zeitgeschichte 2015, p. 191 f. Since an error of law should generally never benefit the offender within the legal order, traditional criminal law adhered to the principle *error iuris nocet*, which implies that an error of law is detrimental to the offender and results in criminal liability. This reflected the distinction between misconceptions of fact (*error facti*) and misconceptions of law (*error iuris*). Since awareness of the factual circumstances constituted a prerequisite for intent, a person who was mistaken regarding a factual element did not act intentionally; accordingly, *error facti non nocet*. To this day, popular wisdom remains convinced: *Ignorance of the law is no excuse*.

104 – [BGE 148 IV 298](#) consid. 7.6.

105 – [BGE 75 IV 150](#) consid. 3.

106 – [BGE 129 IV 238](#) consid. 3.1.

107 – Similarly, see Weise/Koch (n. 84), p. 229, who state that emergency service personnel generally know from their training that failure to act can be punishable by law. Most people understand that they are obliged to act in certain situations.

108 – See also (albeit in the context of attempted suicide) [SAMS Decisions on cardiopulmonary resuscitation](#) (n. 16), p. 26, (“*In doubtful cases, CPR should be attempted (unless the prognosis is wholly unfavourable) whenever it cannot be unequivocally assumed that CPR would be refused by the patient, even if capacity were regained.*”).

109 – See Interverband für Rettungswesen ([Interassociation for Rescue Services](#)); for the “*in dubio pro reo*” principle, see [Art. 10 para. 3 CrimPC](#) (Swiss Criminal Procedure Code of 5 October 2007, CrimPC; [SR 312.0](#)): “*Where there is insurmountable doubt as to whether the factual requirements of alleged offence have been fulfilled, the court shall proceed on the assumption that the circumstances more favourable to the accused occurred.*”

110 – As explained above, emergency doctors and paramedics may also be liable to prosecution for homicide or manslaughter by omission due to their contractual position as guarantors.