

A Legal Analysis of the Emergency Medical Services in South Africa

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A Legal Analysis of the Emergency Medical Services in South Africa

by

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ABSTRACT

The purpose of this dissertation is to analyse the Emergency Medical Services (EMS) in South Africa from a legal point of view. The researcher has practical experience in the EMS and this has given her insight as to how the EMS operates, the grey areas in this unique profession and how the EMS is regulated by the South African law.

A brief background of the EMS is given as well as how the system operates now and what EMS providers deal with on a day-to-day basis. This provides a clear picture of how diverse and unpredictable the EMS profession truly is. How the law regulates the EMS is discussed and all the grey areas from a medico-legal point of view are pointed out and analysed. During this discussion, the researcher makes use of her practical experience to explain why certain situations EMS providers have to deal with on a regular basis are so complex and why the EMS is in need of a better regulatory framework. The grounds of justification in medical law are also discussed and applied to the pre-hospital environment.

The researcher made use of the EMS of the United States of America (USA) and the EMS of Australia in the comparative section, analysed how their respective EMS systems operates and how it is regulated by the law. This is ultimately compared to the EMS of South Africa and recommendations were made as to how the regulation of the EMS system, as a whole, can improve in the future.

PLAGIARISM DECLARATION

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Declaration

1. I understand what plagiarism is and am aware of the University's policy in this regard.
2. I declare that this dissertation (e.g. essay, report, project, assignment, dissertation, thesis, etc.) is my own original work. Where other people's work has been used (either from a printed source, internet or any other source), this has been properly acknowledged and referenced in accordance with the requirements as stated in the University's plagiarism prevention policy.
3. I have not used another student's past written work to hand in as my own.
4. I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.

Signature: Nina van Huyssteen

Chapter 1

1. Introduction

The Emergency Medical Services (EMS) can without a doubt be described as a grey area in the field of medical law. Medical law is a fast growing and gripping branch of the public law and allows for a captivating experience when doing research on any topic in this field. Although there is no lack of research in medical law *per se*, very little research can be found on the EMS in South Africa.¹

J.M Kotze mentioned in an article in the SAMJ²: “Paramedics work under difficult and extreme conditions, mostly without the benefit of a medical doctor, which stands in sharp contrast to the normal situation in hospital.”³

Medical law books and articles have a tendency to briefly mention emergency medicine which often does not include any word on the pre-hospital setting and process. The EMS can be seen as one of the first links in the chain of health care services and although the pre-hospital environment is not nearly as regulated and predictable as in-hospital situations, which could ultimately lead to several grounds for litigation, the practitioners in this field are left with very limited legal certainty.

The Constitution⁴ and the National Health Act⁵ (NHA) states that ‘no one can be refused emergency medical treatment’. The Constitutional Court attempted to describe this term as accurately as possible, but when assessing this term, it is clear that it leads to ethical concerns and the lack of a proper definition clearly leads to the abuse and misuse of our emergency medical system.

Although research on this topic is limited, this dissertation will attempt to give more legal certainty for practitioners working in the EMS. Starting at the Constitution and working through to the regulations of the Health Professions Council of South Africa

¹ Van Hoving *et al* *Emergency care research priorities in South Africa*. Division of Emergency Medicine and Health Sciences, Stellenbosch University. SAMJ March 2015.

² South African Medical Journal.

³ Kotze *The role of ambulance services as part of the health care system*. SAMJ 1990.

⁴ The Constitution of the Republic of South Africa (Act 108 of 1996). Section 27.

⁵ The National Health Act 61 of 2003. Chapter 2.

(HPCSA),⁶ this dissertation addresses every legal aspect that could possibly have a role to play in the EMS of South Africa.

2. Motivation for Research

The first ambulance on the road goes back to Napoleon and it was merely a patient transporter.⁷ Today, our paramedics consist of qualifications far beyond what was expected during the early days. From splinting a simple fracture to Rapid Sequence Intubation (RSI) of a critical patient, EMS providers have a lot of responsibility on their hands and the fact that their working environment can be anything from a wrecked and burning car to a small shack with only a candle providing light, does not make things any easier.

The pre-hospital environment is a very small area in the field of medical law. When we look at medical law, we tend to think of negligence caused by a surgeon inside an operating room or a General Practitioner (GP) prescribing the wrong medication or treatment, but how often do we think about what happens before we enter the doors of the emergency room? As mentioned earlier pre-hospital medicine is a grey area and very little research can be found on this topic, which leads to legal uncertainty for practitioners in this line of work.

I was previously employed as a Basic Ambulance Assistant (BAA) in the private EMS. I have a passion for pre-hospital medicine and having a legal background causes me to look at things from a different point of view. The EMS is completely different from any other career. As first responders, we tend to find ourselves in dangerous and adrenaline filled situations. Switching from a normal day to absolute focus in a traumatic situation is something we deal with on a regular basis. In this study, I use my involvement in the pre-hospital environment to describe the EMS of

⁶ Also referred to as the HPCSA.

⁷ Keenan *Ambulance services in SA – 'past present and future' Hospital Supplies'* March 1990.

South Africa from a practical point of view while focussing on the medico-legal aspects of this special field within medical law.

3. Research Problem, Assumptions, Research Questions and Outcomes

The research problem emanates out of the fact that there is a serious lack of research in medical law on the EMS. Some sort of regulated framework is needed to address all the different situations EMS providers deal with to ultimately provide more legal clarity and give guidelines from a legal perspective.

The assumptions made and the research questions asked are very broad to cover all legal aspects pertaining to the EMS. The first key assumption is that the EMS is regulated by the NHA, the Health Professions Act (HPA) as well as the HPCSA and that all ethical and legal aspects are regulated within this framework.

From there on, the broad assumption basis of this dissertation is as follows: The lack of a proper definition of emergency medical treatment lead to difficulties as to when there can be said that the system is being abused or misused and this ultimately leads to other assumptions being made. These assumptions spread out of the fact that there is uncertainty because of the limited research in this field.

The assumptions were made that there is uncertainty as to when EMS providers may or may not refuse to transport patients where there is no medical emergency; the fact that the rights of patients have become too dominant in relation to their responsibilities; that the law currently does not take into account the hostile environment that practitioners work in and the fact that legal documentation is not properly understood by practitioners.

The EMS consists of numerous ethical concerns and the issues of consent and informed consent could be more problematic than in hospital situations. The EMS is surrounded by situations that could lead to liability, for instance if DNR (Do Not

Resuscitate) orders are not properly understood or if a practitioner practices outside of his or her scope or the level of care is downgraded.

A further assumption is then made that medical professionals in this line of work will have some sort of protection. Although South Africa does not have *Good Samaritan* laws, the recognised grounds of justification in medical law could be seen as a safety net for EMS providers especially with regards to necessity and unauthorized administration.

The National Health Insurance (NHI), when implemented, will certainly play a role in the operating of the EMS and the fact that there is so much emphasis placed on patient safety will affect the system as a whole.

The result of these assumptions is the research questions asked that forms the structure of this dissertation. The first question asked is how the EMS is regulated by the Health Professions Act and the HPCSA. Thereafter the term emergency medical treatment and all the relevant questions that come forth out of analysing this term will be identified. The researcher briefly deals with the question of the role of the NHI and patient safety in the EMS and then move on to the different situations that could lead to liability or possible grounds for litigation (e.g. Pre-hospital environment; consent; confidentiality; restraining of patients; reducing the level of care; practicing outside of scopes; legal documentation; DNR's; and abandoning of patients.)

This is then followed by questions as to how EMS providers are protected. What protection does the recognised grounds of justification in medical law give practitioners, how should practitioners deal with ethical issues and the abuse and misuse of the system, how does the USA and Australia protect their medical professionals from a legal point of view and what can South Africa learn from them.

In Pretoria alone, there are a large amount of EMS companies registered. There are certain rules and regulations that they have to adhere to and these regulations are there to ultimately protect the rights of the patients. These regulations as well as the effect that these fly-by-night services has on the patients' rights are assessed and the ethical issues are looked at.

Evidently the rules of medical law in general are applicable on the different branches of the medical profession and thus this dissertation uses the rules of the doctor patient relationship, the doctor's rights and duties as well as due care and skill of doctors and make it directly applicable on EMS providers in their specific branch of the medical profession, while taking into account the environment they work in. Therapeutic privilege, duty to act, the *Imperitia Culpae Adnumeratur* rule⁸, the *Locality rule*⁹ and the type of agreement between practitioner and patient¹⁰ is also analysed with reference to the EMS and the question is asked if the unique circumstances of the pre-hospital field could cause for these rules to be looked at differently?

The proposed outcomes of this dissertation therefore are:

- An analysis of how the EMS is regulated in terms of our law especially with reference to the HPCSA and their professional boards.
- The meaning of emergency medical treatment and the consequences of this controversial term.
- The application of the doctor-patient relationship, a duty to act, due care and skill, practitioners' rights and duties, the *Imperitia Culpae Adnumeratur* rule and the *Locality rule* on the EMS.
- Analysing and explaining how EMS providers should handle numerous situations that occur in practice to ultimately avoid liability.
- Analysing the regulations to be followed in order to protect patients' rights.
- Assessing the protection provided to medical professionals in this field of work.
- An analysis of ethical concerns EMS providers face on a daily basis.
- Comparing South Africa's EMS to that of the USA and Australia in order to see if South Africa's law protects EMS providers adequately.
- Conclusion and recommendations.

⁸ This rule states that a practitioner that engages in an undertaking that requires a certain amount of skill if he does not possess of these skills, will be judged as if he did consist of the particular skill or skills. PA Carstens and D Pearmain. *Foundational Principles of South African Medical Law* (2007).

⁹ *S v Tembani* 2007 (2) All SA 373 (SCA). This rule states that negligence can be expected in certain situations if one takes in account the location of the case/hospital and thus there can be no liability. Carstens & Pearmain. (2007) 637.

¹⁰ Carstens & Pearmain. (2007) 283.

4. Methodology, Comparative Dimension and Limitations

The research problem of this study has a wide angle as the EMS is not well researched and only forms a small drop in the big and evolving field of medical law. This study will address different problems that could lead to liability for EMS providers in the pre-hospital setting, starting at the meaning of emergency medical treatment and working through to the abuse and misuse of the system, as well as different ethical and legal concerns that could cause grounds for litigation like refusal of transportation, informed consent and restraining of patients.

When assessing the definition of emergency medical treatment, the focus will be on the Constitutional case of *Soobramoney*¹¹ where the court attempted to give meaning to the term. The term and how the meaning of emergency medical treatment affects the practical side of things and the legal uncertainty to which it ultimately leads will be explained. Unravelling and explaining this term helps to shed light on some other medico-legal issues that forms part of the study. The Constitution, NHA and the HPA play an important role when looking at this controversial term.

The different research questions postulated emanate from the researcher's practical experience within the EMS. EMS providers deal with various high-stress situations every day and most of those situations, if not all, could evidently lead to grounds for litigation. Throughout this study, these questions will be answered by way of extensive research of pre-hospital medicine in South Africa as well as countries such as Australia and the USA. The researcher's practical experience on the road will be used to demonstrate situations that EMS providers deal with every day. At the end of this study, the researcher sets out how to avoid liability in different situations that EMS providers face as to give more legal clarity in this unique line of work. The pre-hospital setting is not as regulated and secure as inside medical facilities and avoiding liability outside of hospital is a completely different challenge.

¹¹ *Thiagraj Soobramoney v Minister of Health (Kwazulu-Natal)* 1997 (12) BCLR 1696 (CC). <http://www.sajbl.org.za/index.php/sajbl/article/view/4> (Accessed 21 January 2015).

The *Kitching v Premier of the Eastern Cape Province*¹² case as well as other case law and the HPCSA regulations will be used to demonstrate the importance of following protocols and complying with all legal and ethical standards when completing necessary documentation in any pre-hospital emergency. This is of importance because so often there is uncertainty as to where and when the negligence occurred. Was it on the scene of an accident when the EMS providers were attending to the patient or did complications arise because of poor treatment inside the hospital? The *Franks v MEC*¹³ Case is important with regards to negligence caused by EMS providers on scene while handling more than one patient and the risk of contamination of those patients. When the researcher deals with consent and informed consent, the case of *Castelle v De Greef*¹⁴; *Phillips v de Klerk*¹⁵; *Stoffberg v Elliott*¹⁶ and *Lymbery v Jefferies*¹⁷ plays an important role. *The S v Tembani*¹⁸ case is important when assessing if the *Locality rule* plays any role whatsoever in the EMS.

A theoretical analysis approach is used as the research method in order to answer all the research questions. This is the main approach as the aim of this study is to analyse the EMS of South Africa. Thus, the research is very broad and it focuses on several aspects.

It is very clear by looking at the research questions that the aim of the study is to approach different aspects within the EMS which all, in the long run, could lead to liability for practitioners in this field. The aim of this study is to provide greater legal certainty regarding these different situations that EMS providers could find themselves in throughout their thrilling careers.

¹² *Kitching v Premier of Eastern Cape Provinces* 2009 JDR 1301 (ECB).

¹³ *Franks v MEC for the department of Health, Kwazulu Natal*. 2011 ZASCA 84.

¹⁴ *Castelle v De Greef* 1994 (4) SA 408 (C).

¹⁵ *Phillips v de Klerk* 1983 (T).

¹⁶ *Stoffberg v Elliott* 1923 CPD 148.

¹⁷ *Lymbery v Jefferies* 1925 AD 236.

¹⁸ *S v Tembani* 2007 (2) All SA 373 (SCA).

In the EMS, it is very common to make use of abbreviations to explain different situations and levels of qualifications. These abbreviations are introduced and explained in this chapter.

This study is limited to the EMS in South Africa. The EMS in the USA and Australia, however very diverse from state to state, will be assessed, but only to benchmark the effectiveness of our EMS system against other countries and also to make a few recommendations where the EMS of South Africa fall short specifically regarding the law. The focus of this study is however not to compare our EMS system to those of other countries, but the researcher uses several USA case law such as the *Hackman*¹⁹ and *Zepeda*²⁰ cases to demonstrate the fact that the public is more than willing to take EMS providers to court and that the public in South Africa is becoming more aware of potential liability in the EMS. As the researcher was employed in the private EMS system, this study is more focussed on this specific area and very little information will be provided on the public EMS services of our country as the length of this study is limited. The researcher does however mention it briefly in areas where relevant.

5. Overview of Chapters

In order to have a better understanding of the EMS in general, Chapter Two gives a brief overview of the history of the EMS as well as explains the pre-hospital environment from a practical point of view. This sheds light on the type of situations EMS providers deal with and why these situations could lead to grounds for litigation. How the EMS is regulated by the NHA, HPA, HPCSA and other provincial legislation is also discussed.

¹⁹ *Hackman v American Medical Response (2004) WL 823206 (Cal. App. 4 Dist.)* (Unpublished Opinion).

²⁰ *Zepeda v City of Los Angeles (1990) 223 Cal. App. 3d 232 [272 Cal. Rptr. 635]*.

After dealing with the field of emergency medicine in general, Chapter Two focusses on the term emergency medical treatment and the problems that emanate out of the definition of this term, or rather the lack of a clear definition. The Constitution, legislation and case law on emergency medical treatment is analysed and the practical implications of this term is assessed. In this Chapter, a picture is also painted of the abuse and misuse of the EMS system and the medico-legal and ethical issues that EMS providers have to deal with because of this growing problem.

In Chapter Three the research questions that could lead to liability for EMS providers are focused on separately. Firstly, the difficulties of pre-hospital medicine is described and then medico-legal issues such as consent and informed consent; refusal of treatment; negligence; confidentiality; restraining of patients; legal documentation; reducing the level of care; practising outside of scopes; patient abandonment and lastly the role of the NHI and patient safety are all critically analysed. The purpose of this chapter and the analysis of these situations are to provide more legal certainty for EMS providers when dealing with such situations. This chapter also discusses the doctor patient relationship, duty of care, due care and skill, *the Imperitia Culpae Adnumeratur* rule and the *Locality rule* and how it is applicable on the EMS. Lastly, this chapter looks at the regulations the EMS has to follow and how the competitiveness of different services can affect the rights of the patients.

Chapter Four, the penultimate chapter, focusses on the legal protection of medical professionals in the EMS. In this chapter, the grounds of justification in medical law and how these justifications work in the pre-hospital setting are assessed. This chapter also contains a comparative section where the EMS of the USA and Australia are assessed and compared to South Africa's EMS. The aim of this chapter is to explain how to best avoid liability and to give legal clarity by illustrating the law applicable on EMS.

This dissertation shall conclude with Chapter Five. In the final chapter, each of the previous chapters are summarised and concluding remarks and recommendations are made.

6. Terminology Section

In the EMS, there are endless abbreviations used by EMS providers to explain different situations. Some of the more often used terminology and those that are used in this dissertation, are explained in this section.

There are three levels of care in the EMS: Basic Life Support (BLS), Intermediate Life Support (ILS) and Advanced Life Support (ALS). Every level consists of different qualifications. The ILS and ALS practitioners are both registered with the HPCSA as independent practices whereas the BLS practitioners are registered as supervised practice, which means that they work under the supervision of someone with a higher qualification. The different qualifications that falls under each level are discussed below and it becomes evident that the lines becomes quite blurry with regards to the specific level under which some of the qualifications falls.

Personnel in the EMS use different priorities to explain the seriousness of a patient's condition. P1 (Priority 1 or Red/Orange code), is a critical patient that needs immediate attention to prevent death or serious injury. P2 (Yellow code), is a patient that can be considered as serious but not in grave danger. P3 (Green code), is often described as the walking wounded. These patients do not need immediate attention and can usually go to a doctor on their own time if needed, although these patients make up a great deal of patients transported by ambulance services. P4 is used to describe that a person is dead and P4 hold is used to describe the critically injured patient with no prognosis or chance of survival. P5 is a relatively new local term that is used to describe those who are uninjured.

There are numerous medical abbreviations used by EMS providers in this line of work but will not be relevant in this dissertation. If used, the term is explained in a footnote.

7. Conclusion

It is quite clear by looking at the above that this dissertation will explore a field within medical law that seems to be less recognised or forgotten about: a field that could possibly mean the difference between life and death when you find yourself in an unexpected and traumatic situation.

Medical law has grown tremendously over the past years and the term medical negligence has become part of the vocabulary of many. This puts a lot of pressure on medical practitioners and medical professionals in the EMS are no exception. It is important for anyone in the medical profession to familiarise themselves with the law applicable as to prevent themselves from being caught in the middle of a legal battle.

The EMS is completely different from any other medical field and words such as adrenaline, danger and golden hour describes the EMS quite well. The situations EMS providers find themselves in throughout their careers are unique and mostly unplanned and unexpected and therefor EMS providers are entitled to legal certainty so that they can fulfil their duties as the first link in the health care system without constantly questioning their actions. A regulated framework providing guidelines for certain situations could possibly be the solution to this problem.

This dissertation analyses all the medico-legal aspects applicable to the EMS with a theoretical as well as a practical approach as to provide more legal clarity in this exclusive field in medical law.

Chapter 2

The EMS of South Africa

1. Overview

This chapter briefly discusses the history of the EMS in South Africa as well as the EMS of today. It gives an idea of what the EMS entails and what EMS providers deal with in their careers. After getting an understanding of the EMS in general, this chapter analyses how this profession is regulated by the law from the Constitution through to the EMS Regulations. It also focuses on the term Emergency Medical Treatment or rather what a medical emergency truly is. This chapter paints a picture of the difficulties that flow out of a lack of a proper definition especially with regards to the misuse and abuse of the EMS.

2. History of South Africa's EMS

The role of the first ambulances in South Africa and across the world was to rapidly transport injured patients to hospital. No treatment was given on the scene of the accident or en route to hospital as the individuals working on these vehicles were not medically trained. Initially these ambulances were only used in wars to transport injured soldiers.²¹

One of the first ambulance services in South Africa started as early as 1877 and was known as the St John's Ambulance Brigade used originally in industrial and coal-mining regions. Personnel trained in First Aid were of prime importance during the frequent accidents which occurred in the workplace. They also played an important

²¹ *History of Ambulances*. <http://www.emt-resources.com/History-of-Ambulances.html>. (Accessed 3 August 2015).

part in the South African War on 11 October 1899 in assisting with casualties from battle and disease.²²

Very soon, this started to change and the role of the ambulance became more significant. The technique of 'scoop-and-shoot' made place for basic first aid rendered on scenes. It was only in the 1970's that South Africa recognised the role of the paramedic. The Emergency Medical Assistant (EMA) Course was the first medical training for pre-hospital situations. It consisted of more advanced training than first aid and allowed for amongst others intra-venous (IV) therapy.

The EMS was always offered in conjunction with the provincial fire services and this was the position until well after the Second World War. As the role and the capability of the ambulance and its crew developed, it created space for an independent health service. The Health Act of 1977²³ made the ambulance services the responsibility of the provincial administration. Some provinces ran the ambulance service as an independent health service whereas other provinces stuck to the combined service where the ambulance service worked in conjunction with the fire departments. Soon, a training school for pre-hospital medical services established in every province and the training became more and more advanced. The more advanced training required for individuals to register with the South African Medical and Dental Council²⁴ as supplementary health services personnel. Along with the training that got more progressive, so did the equipment and vehicles used to respond to emergency situations and transport the sick and injured to hospital.²⁵

As part of the training, the personnel had certain protocols to adhere to and their scopes and abilities were very strictly regulated. The EMS continued to grow and the abilities of the personnel in this branch of the medical profession soon became more cutting-edge than ever imagined.

²² Beighton and de Villiers *The St John Ambulance Brigade in the South African war, 1899-1902 Casualties and Memorials in South Africa*. Military History Journal. 1997.

²³ Health Act No 63 of 1977.

²⁴ Now called the HPCSA.

²⁵ Kotze *The role of the ambulance service as part of the health profession*, SAMJ 1990.

3. South Africa's EMS today

Nowadays our ambulance services have abilities far beyond what was expected previously. It can be seen as an extremely effective medical service that quite often means the difference between life and death. The EMS is a system used to provide acute pre-hospital care and to transport patients with illnesses and injuries that make it impossible to transport themselves.²⁶

There are two basic types of EMS models in the world today: The European, which is physician based, and the Anglo-Saxon model which is paramedic based. In the European model, doctors work on ambulances and/or response cars and provide hands-on treatment to critical patients. They are merely assisted by paramedics who are supervised and have little autonomy in clinical decision making. In the Anglo-Saxon model, there are little to no doctors involved. The South African EMS uses an Anglo-Saxon model. Doctors are seldom involved in a pre-hospital setting in South Africa.²⁷

Most EMS services have different levels of care. The ambulance may have anything from a basic to an advanced capability and some systems make use of a combination of ambulances and response vehicles. In addition to this, a Helicopter Emergency Medical Service (HEMS) may be available in certain areas. HEMS is invariably an ALS level of care and is used according to strict dispatch criteria designed to give patients with the best prognosis a better chance of survival. Before authorization for a flight will be given, the paramedics on scene will have a short discussion with the flight desk at the control centre to confirm if the patient meets the specific flight criteria.

The EMS consists of provincial as well as private services. Most of the provincial services are still in conjunction with the fire departments where the private services are all independent health services or forms part of a hospital group. The colocation

²⁶ *Emergency Medical Services explained*. Health savvi.
<https://www.getsavvi.co.za/community/medical-services/emergency-medical-services-explained>
(Accessed 31 August 2015).

²⁷ MacFarlane *et al International EMS systems: South Africa-Past, Present, Future* 2005 NCBI.
<http://www.ncbi.nlm.nih.gov/pubmed/15680521> (Accessed 30 August 2015).

of ambulances with fire apparatus is common in South Africa, although they are used for two independent services.²⁸ It is difficult to separate the two sectors as both work in conjunction with one another to render emergency services to the public.²⁹ The private EMS mainly focus on the 'paying clients' or those with medical aids where the public EMS caters for those without the financial means, although both sectors have the responsibility to help those in need and administer lifesaving treatment in an emergency irrespective of the patients ability to pay.

Today our EMS providers consist of one of the following qualifications: BAA (Basic Ambulance Assistant), which falls under BLS; AEA (Ambulance Emergency Assistant), which falls under ILS; Paramedic (which includes the Critical Care Assistants (CCA) and Ndip's (National diploma)), which falls under ALS; and lastly ECP (Emergency Care Practitioner) which also falls under ALS. Today each of the qualifications has their own training and scopes of practice and individuals that practice under any one of these qualifications have to register with the HPCSA, previously the Medical and Dental Council of South Africa.³⁰ The EMS is regulated by the NHA,³¹ the HPA³² as well as the HPCSA. There is also provincial EMS legislation like the Gauteng Ambulance Services Act. This is discussed in more detail below.

On an ambulance, you will usually find a BLS provider as well as an ILS provider. The ALS providers are each placed on a rapid response car for quicker response times and are usually sent out along with the ambulance for back up in serious medical emergencies. The training of BLS providers covers BLS techniques (including Cardio Pulmonary Resuscitation (CPR) and first aid), emergency care and the use of ambulance equipment, including Automated External Defibrillators (AED). BLS providers are trained to assist with various emergency medical interventions and could be seen as the right hand to those with higher qualifications. The training of an ILS provider is more advanced as it allows for IV therapy along with the

²⁸ n 26.

²⁹ Toubkin *Emergency medicine – private sector trends*. Emergency Services SA/Occupational Risk 2010.

³⁰ For Professionals – Professional Boards Overview. <http://www.hpcs.co.za/PBEmergencyCare>. (Accessed 14 September 2015).

³¹ The National Health Act 61 of 2003. From now on referred to as NHA.

³² Act 56 of 1974. Also the Health Professions Amendment Act (No 29 of 2007). From now on referred to as HPA.

administration of various drugs like B2 stimulants and dextrose. They are also qualified to do needle Cricothyroidotomy and needle Thoracocentesis, as well as three lead ECG interpretation and manual external defibrillation. Lastly the ALS capabilities consists of various advanced life support techniques which includes numerous drugs such as Morphine for pain management and Midazolam which is a short acting central nervous system depressant. ALS providers are trained to intubate patients pre-hospitally and are capable of interpreting a twelve-lead ECG. These are only a few key capabilities out of a very large spectrum.³³

In between these qualifications, there is also a qualification called Emergency Care Technician (ECT). The scope of an ECT is more advanced than an ILS provider but less advanced than that of an ALS paramedic. This qualification is obtained through a two year course and is run at diploma level.

The above mentioned qualifications can be obtained by way of attending a short course at an accredited facility, although these courses will soon come to an end. Each has different requirements and the higher the qualification the longer the course. If someone is qualified as a paramedic, the qualification could have been obtained by way of a short course (CCA) or by way of a three year diploma (Ndip). A four year degree evidently broadens the scope of the individual and their qualification will be called ECP (Emergency Care Practitioner) which is a separate register with the HPCSA.

The scopes of the above mentioned qualifications are regulated by the HPCSA and practicing outside of these scopes can lead to negligence and serious disciplinary action. Although EMS providers learn a lot while working on the road and their capabilities go far beyond their scope of practice, they should refrain from practicing outside of their scope as this could lead to serious law suits and/or disciplinary action from the HPCSA. Practicing outside of your scope of practice is discussed in more detail in Chapter Three.

The short courses will be stopped in the near future and make place for new pre-hospital courses. These courses will be more in line with the qualifications in

³³ *Regulations defining the scope of the profession of emergency care.* HPA 56 of 1974. Published under Government Notice R48 in Government Gazette 23040 January 2002.

America which make use of the Basic Technician (ECT-Basic), Intermediate Technician (ECT-Intermediate) and the Advanced Technician (ECT-Advanced).³⁴ The Department of Health, through the South African Qualifications Authority (SAQA), believe it is necessary to remove the short courses system due to this system not meeting the requirements of the National Qualifications Framework (NQF). Experts however believe that this may prompt the complete collapse of the EMS training system in South Africa.³⁵ The Netcare Education Faculty of Emergency and Critical Care (FECC) will replace the short courses with a one year Emergency Care Assistant (ECA) Higher Certificate and a two year Emergency Care Technician (ECT) Diploma. This will take place as early as 2016. These changes are in line with the HPCSA and Department of Health plans for advancing the profession.³⁶ The ECP qualification, which is a four year degree, will still be continued at tertiary facilities such as the University of Johannesburg (UJ).

The private EMS, which is the focus of this dissertation, has developed and expanded tremendously over the past number of years. There are several private EMS companies operational in Pretoria alone. Some are client based and only do inter-hospital transfers or events, whereas the bigger companies are used by the general public for any medical emergency from Motor Vehicle Accidents (MVA) to heart attacks, respiratory emergencies and many other emergencies at home or at the workplace. The EMS has grown to cover a vast area of emergencies or rather what the public perceive as medical emergencies.

When someone finds themselves in a medical emergency or knows or see someone that needs emergency medical treatment, they will call an emergency number that will link them to a control room of that specific EMS Company they called. They will then be asked various questions to find out what the medical emergency is and if it is necessary to send out the response vehicle or not. After the location of the incident

³⁴Shah *The Formation of the Emergency Medical Services System*. Am J Public Health. 2006 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470509/> (Accessed 1 September 2015).

³⁵ *Decision to Scrap Emergency Medical Services Training System Must Be Reversed*, May 2010, <http://www.da.org.za/archive/decision-to-scrap-emergency-medical-services-training-system-must-be-reversed/> (Accessed 25 July 2015).

³⁶ Netcare911 Official Website. http://www.netcare911.co.za/live/content.php?Session_ID=7eca8fb9844ac6298864d42c3445a86c&Item_ID=6864 (Accessed 1 September 2015).

is established, the closest ambulance will be dispatched. This typically happens by way of a SMS that is sent out to the crews on the ambulance and response car with the locations as well as a short description of the medical emergency. Irrespective of the type of emergency, the ambulance and response car will activate their lights and sirens and respond to that location. The reason for this is that quite often the paramedics will arrive on the scene and the situation will be more serious and life threatening than expected. The information given by the caller cannot always be presumed as correct and thus every call has to be treated as a true emergency until proven otherwise, which could in turn be dangerous to EMS providers and the public.

If someone calls the provincial emergency number³⁷, the control room will send out a provincial ambulance. The private services also have the ability to contact a service provider if they do not have ambulances available at that time.

Ambulance response times are most widely used to monitor the effectiveness of the EMS, although this has always been difficult to evaluate because of multiple variables.³⁸ The golden hour is a very important term in the EMS and the time between a call received and a patient being dropped off at an appropriate medical facility could mean the difference between life and death. MedStar EMS Associate Director for Operations M. Zavadsky said: “Response times are how EMS providers compete for contracts, and it’s how EMS leadership proves to the community that it’s providing quality service”.³⁹

Some countries make use of a ‘scoop-and-shoot’⁴⁰ system whereas others believe in ‘stay-and-play’⁴¹. There has been numerous research studies done on these two different manners of treating patients and which system has the highest mortality rate at the end of the day. It has been mentioned that interventions beyond BLS level is not always beneficial to the patients and that it appears to be better to rather

³⁷ 10177 for landlines and 112 for cell phones.

³⁸ MacFarlane and Benn *Evaluation of emergency medical services systems: a classification to assist in determination of indicators*. Emergency Medicine Journal, 2003.

³⁹ *The great ambulance response time debate continues: Is speed the best measure of an EMS system?* T McCallion, EMT. <http://www.jems.com/articles/2012/02/great-ambulance-response-time-debate.html> (Accessed 12 August 2015).

⁴⁰ This is a technique where practitioners load the patient as quick as possible and transport them to the closest hospital without wasting any time on the scene.

⁴¹ This technique is different from scoop and shoot, because here EMS providers will first give all possible pre –hospital treatment on scene before transporting the patient to hospital.

transport the patient rapidly to the closest appropriate facility rather than to spend too much time on scene.⁴²

Today, there is a big difference between what medical trained personnel and the general public see as medical emergencies. Ambulances go out to non-emergent calls every single day and unfortunately this misuse of the system is an ongoing problem, but it is a fact that the EMS of today plays a bigger role in the health care system than ever imagined and is a vital part of any emergency. The South African Private Ambulance and Emergency Services Association (SAPAESA) believes that South Africa has one of the best and most comprehensive EMS qualifications in the world.⁴³ B. Dessena, a paramedic with more than 20 years of experience mentioned in her book, *Tales from my Stethoscope*, that South Africa might be behind other countries in some areas, but because of the frequent exposure to trauma as a result of a fairly violent society, South Africa has undoubtedly the best paramedics in the world.⁴⁴

4. Pre-Hospital Environment

The best way to describe the pre-hospital environment is by using words such as unpredictable, unique, adrenaline filled, dangerous, emotional and rewarding. Expect the best and be prepared for the worst, is probably the best motto to live according to when you work in the EMS. The fact that you have absolutely no idea what each day holds for you is both exciting and terrifying at the same time, which stands in sharp contrast to a normal eight to five office job.

When working in the EMS it is expected of you to deal with a vast array of medical emergencies. From MVAs, Pedestrian Vehicle Accidents (PVA), attempted or completed suicides, cardiac arrest, respiratory arrest and terminal illnesses to

⁴² Smith and Conn *Prehospital care- Scoop and run or stay and play?* International Journal of the Care of the Injured, Nov 2009 [http://www.injuryjournal.com/article/S0020-1383\(09\)00553-1/abstract](http://www.injuryjournal.com/article/S0020-1383(09)00553-1/abstract) (Accessed 27 September 2015).

⁴³ n 36.

⁴⁴ Dessena *Tales from my stethoscope. True stories from a South African paramedic.* 2010. 18

Sudden Infant Death Syndrome (SIDS), psychotic episodes, child birth and flu or hiccups. This is only to mention a few and understandably each case is unique. You deal with the rawest human emotions when someone stands to lose or has just lost a family member. Most often, EMS providers are there the precise moment the emotional wheels come off and witnessing this time and again does not make it any easier. Without a doubt, some of the worst calls EMS providers deals with are suicides. Unfortunately, there are so many different ways of ending your life, and every time EMS providers think they have seen it all, they get surprised by the awful sight of yet another way to commit the sad and depressing act. The researcher herself has also experienced many suicides and just as she also thought she has seen it all, a man in his 50's decided that cutting off his entire hand with a steak knife will be an effective method, and so it was. The statistics for suicides are horrific. In South Africa, the average suicide is 17.2 per 100 000 (8% of all deaths). This relates only to deaths reported by academic hospitals. The real figures are much higher.⁴⁵

Working 12 hour shifts and 'chasing' one emergency after the other can be a draining experience both physically and emotionally, but for most of the personnel working in the EMS, this is just a normal day, and as mentioned earlier, switching from a normal day to absolute focus in a traumatic situation is something we deal with on a regular basis.

As rewarding as this career may be, it doesn't come without its difficulties and frustrations. As one can imagine, this is not one of the safest professions in South Africa. The pre-hospital environment is filled with countless dangers and occupational hazards. Every day EMS providers walk into the homes of people they have never met and rural areas that they are not familiar with, without any form of police presence. You and your partner could possibly be walking into a very unsafe situation without the slightest idea of any possible danger. You get confronted with uncooperative or aggressive patients, family members or bystanders and these types of situations could get out of hand in a blink of an eye. Unfortunately, it is also a reality that EMS providers get robbed and assaulted more frequently than one

⁴⁵ *Teen suicide*. The South African Depression and Anxiety Group (SADAG). http://www.sadag.org/index.php?option=com_content&view=article&id=1840&Itemid=153 (Accessed 3 October 2015).

would expect, and this while they are only trying to come to the aid of others in need. Recently, an Eastern Cape EMS ambulance crew was robbed at gunpoint in New Brighton. Spokesperson S. Kupelo said, “Two people lured them into an alley under the impression they will take them to the patient. A gun was produced and the crew was robbed at gun point”.⁴⁶ Unfortunately, this is a scary reality and can definitely be seen as a big danger that forms part of the profession.

In the EMS it is not only the public and crime that holds dangers, but the surroundings EMS providers work in and the hazards associated with it, could be even a greater threat to their wellbeing and lives. Standing next to a highway in the middle of the night attending to a MVA or PVA victim is anything but safe as oncoming traffic could cause a secondary accident and possibly injure EMS providers. Climbing into small areas and wrecked cars or going into construction sites also forms part of their daily jobs and brings dangers of its own. Dealing with patients with various diseases that could be contagious or cutting or pricking yourself accidentally with a dirty needle, is also very common, and thus it could be said that regrettably, the health of EMS providers comes in jeopardy on a daily basis. The researcher experienced this first hand when a situation that should be remembered as a beautiful life changing experience changed into a month course of Anti-Retro Viral (ARV) medication. At the end of a shift, a pedestrian waved the crew down as the researcher and her partner were on their way back to base. The lady was going into labour and needed assistance and transport to the nearest hospital. Alas the unborn baby decided that it was time to make his long awaited arrival right there in the ambulance. In between all the excitement, unexpectedness and an ambulance that was driving as fast as possible to get to the hospital in time, the researcher accidentally cut her finger with the blade that was used to cut the umbilical cord. The mother was HIV positive and so the night ended with frustration and nausea after drinking the first medication within that crucial 24 hour period.

Working in the EMS requires one to work long and difficult hours. Most services make use of 12 hour shifts which usually turn out to be 13 or 14 hours. Waking up at three am in the night to assist others in need is nothing abnormal. Sometimes you

⁴⁶ Wakefield *PE ambulance crew robbed at gun point*. News24. 30 Sept 2015.

get up for non-emergent calls and sometimes you need to wake yourself up very quickly when you get confronted with a true emergency that consumes up all your focus and energy. The EMS is a field that puts strain on your body from both a physical and emotional point of view. You have to be willing to work long hours, pick up heavy patients and carry them out of their homes or out of a ditch next to the road, carry heavy equipment up a flight of stairs or climb into a small area or wrecked vehicle. At the end of the day after years in the profession, EMS providers struggle with numerous medical problems because of the physical activities this career consists of, and getting burnt out emotionally because of the continual exposure to human suffering, does from time-to-time cause careers to end on a bad note.

Unfortunately, there is a big gap between the general public and those with medical training when it comes to what a medical emergency truly is. Along with those serious MVAs, PVAs, cardiac arrests and other serious medical or trauma emergencies, comes the non-emergent calls, which make up a great deal of 'emergencies' EMS providers attend to. Sadly, this is a growing problem in the EMS and we see an increase in the misuse and abuse of the system, which is probably one of the biggest frustrations when working in this field. Some people find it appropriate to phone for an ambulance when they have been struggling with a cold for a couple of days, and this while there is a car in perfect working condition standing in the driveway. The sad truth is that a great part of the public seems to mistake an ambulance for a taxi where the medical aid will take care of the bill, while there could be someone out there in true need of emergency medical assistance.

It is clear that along with the adrenaline rushes, uniqueness and great reward that goes hand in hand with the EMS, comes big frustrations, dangers and physical and emotional strain. The pre-hospital environment is not for everyone and out of practical experience it is very true when they say that one has to be born for this job and have an absolute passion for the EMS to survive and thrive in this line of work.

5. Regulation of the EMS

The EMS is controlled by various legislative frameworks and governing bodies. In this section the researcher analyses how the Constitution, which is the highest law in South Africa, followed by the NHA, HPA, the HPCSA and its professional boards as well as EMS regulations and provincial legislation such as the Gauteng Ambulance Services Act, regulate the EMS. The EMS is a branch of the medical profession and just like all the other medical professions in South Africa, there are certain rules and regulations it needs to comply with in order for it to function properly and to the best of its abilities.

5.1. The Constitution of the Republic of South Africa

The Constitution of the Republic of South Africa states the following:

27. Health care, food, water and social security

(1) Everyone has the right to have access to –

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.⁴⁷

⁴⁷ The Constitution of the Republic of South Africa, Act 108 of 1996. Section 27.

Section 27(3) of the Constitution makes it clear that no one may be refused emergency medical treatment. This is a constitutional right and may only be limited if it is allowed according to Section 36⁴⁸ of the Constitution which states the following:

The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including :

- a) the nature of the right;
- b) the importance of the purpose of the limitation;
- c) the nature and extent of the limitation;
- d) the relation between the limitation and its purpose; and
- e) less restrictive means to achieve the purpose.

Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

Section 27(3) is important in terms of the EMS and any medical facility with an emergency unit that is able to provide emergency medical treatment. What the term emergency medical treatment means and the implications of this term are dealt with later on in this chapter.

5.2. National Health Act

The NHA provides a framework for a uniform health system in South Africa based on the obligations imposed by the Constitution of the Republic of South Africa with regard to health services.⁴⁹

⁴⁸ Limitation of Rights clause. The Constitution of the Republic of South Africa, Act 108 of 1996. Section 36.

⁴⁹ Mcquoid-Mason and Dada *A-Z of Medical Law*. (2011) 285.

The NHA states the following:

5. Emergency treatment

A health care provider, health worker or health establishment may not refuse a person emergency medical treatment.⁵⁰

The NHA confirms in Section 5 that no one may be refused emergency medical treatment. According to the NHA, the term 'health care personnel' includes health care providers and health care workers. 'Health care providers' are defined as persons providing health services in terms of any law, including the Health Professions Act, the Nursing Act, the Pharmacy Act and the Dental Technicians Act. 'Health workers' are defined as persons providing health services to users but do not include 'health care providers'.⁵¹ When looking at Section 5 one can ask the question what the situation will be if the health care provider or health worker does not have any experience in medical or trauma emergencies. This phrase is very broad and does not say a lot more on emergency medical treatment than Section 27(3) of the Constitution.

The NHA states that the head of a provincial department must, in accordance with national health policy and the relevant provincial health policy in respect of or within the relevant province provide and co-ordinate EMS and forensic pathology, forensic clinical medicines and related services, including the provision of medico-legal mortuaries and medico- legal services⁵²

Chapter 11 of the NHA states that the Minister, after consultation with the National Health Council or the Office, as the case may be, may make regulations regarding the EMS and emergency medical treatment, both within and outside of health establishments.⁵³ Any regulations made are thus prescribed in terms of this act. At the end of this section, the new EMS regulations are discussed.

The NHA sets out the rights and duties of users and health care personnel which includes EMS providers and users of the EMS. The Act also deals with various terms

⁵⁰ Act 61 of 2003, Chapter 2 Section 5.

⁵¹ *Ibid.*

⁵² Act 61 of 2003, Chapter 4 Section 25(20)(m).

⁵³ Act 61 of 2003, Chapter 11 Section 90(1)(m).

and definitions such as informed consent; refusal of consent; confidentiality and the structure of the health system to mention a few. In Chapter 10 of the NHA, the Act deals with the office of health standards compliance, boards, inspections and environmental health investigations, health officers and inspectors and complaints and appeal procedures. This evidently plays an important role in any medical profession or branch including the EMS.

All health care providers should familiarise themselves with all the relevant provisions of the act, in particular those dealing with the rights and duties of health care users as well as informed consent and confidentiality. Any breach of a provision of the NHA may result in a criminal offence or disciplinary action by the HPCSA.⁵⁴

The National Health Council was established in terms of the NHA to advise the Minister of Health on policy and legislation in order to preserve and provide health services to all of South Africa. The functions of the Council are to advise the Minister of Health on policy affecting health in the private and public sector, financing of health services, coordination of health services, the development of health technology and other planning, production and management of the health care system which will include the EMS. All branches of the medical profession may be affected by the recommendations from the National Council.

5.3. Health Professions Act

The Health Professions Act also plays a vital role in the regulation of the EMS. The HPA's title states the following:

To establish the Health Professions Council of South Africa and professional boards; to provide for control over the education, training and registration for and practising of health professions registered under this Act; and to provide for matters incidental thereto.⁵⁵

⁵⁴ n 53.

⁵⁵ Health Professions Act 56 of 1974.

The role of this Act is to establish and explain the HPCSA and its professional boards. This includes its objects, functions and powers. Chapter Two of the act controls all the training, education and registration of all health care workers as well as the suspension and appeal process. Chapter Three and Four deals with the offences and disciplinary powers of the Council.

All of the above mentioned is applicable on the EMS, as all EMS providers must register with the HPCSA. It is thus clear that the EMS is regulated by the Council along with all the other medical professions.

The title "Paramedic" is protected by means of the HPA and the HPCSA.

"Paramedic" means a person registered with the Health Professions Council of South Africa as a Paramedic in terms of the Health Professions Act, 1974 (Act no.56 of 1974).⁵⁶

As mentioned earlier, the title 'Paramedic' is specifically created for the Critical Care Assistants and the Ndip's. The most advanced qualification, the ECP, has their own register called the Emergency Care Practitioners.

5.4. Provincial Ambulance Service Acts

The long title of the Gauteng Ambulance Services Act is as follows:

To provide for the regulation of the delivery of ambulance services in the Province; to establish the Gauteng Ambulance Services Board; to provide for the accreditation, registration and licensing of ambulance services; and to provide for matters connected therewith.⁵⁷

⁵⁶ Emergency Medical Service Regulations, Government Notice, No. 37869. http://www.gov.za/sites/www.gov.za/files/37869_rg10239_gon585.pdf. (Accessed 11 September 2015).

⁵⁷ Gauteng Ambulance Services Act, No. 6 of 2002. LegalB's Resources for Africa. http://www.legalb.co.za/SAPROV/GP/gp_2002_006_000-Ove-v20021128.html (Accessed 12

This provincial Act regulates all the operational and administrative functions of ambulance services based in the Gauteng Province.

The Western Cape Ambulance Services Act is almost identical to the Gauteng Ambulance Services Act and its main function is also to regulate the operational and administrative functions of ambulance services based in the Western Cape.⁵⁸

In the Free State Province, the Free State Provincial Health Act⁵⁹ makes provision for the EMS. Section 38 and 39 of the Act very broadly regulates the EMS and the registration of a private ambulance service.

5.5. HPCSA and Professional Boards

The Council guides and regulates the health professions in the country in aspects pertaining to registration, education and training, professional conduct and ethical behavior, ensuring continuing professional development, and fostering compliance with healthcare standards. All individuals who practice any of the health care professions incorporated in the scope of the HPCSA are obliged by the Health Professions Act No. 56 of 1974 to register with the Council. Failure to do so constitutes as a criminal offence.⁶⁰

The HPCSA regulates the EMS in numerous ways. The HPCSA consists of several professional boards that have been established for different branches of the health professions in order to guide the branches concerned and to protect the public or 'users' of the specific branches. The HPCSA are also able, in terms of Section 4, to render financial aid to professional boards to enable them to perform their

September 2015). See also <http://www.enviroleg.co.za/provinces/GAUTENG/Gauteng%20Ambulance%20Services%20Act%202002.pdf> (Accessed 12 September 2015).

⁵⁸ Western Cape Ambulance Services Act, No. 3 of 2010. https://www.westerncape.gov.za/text/2004/2/wcape_ambulance_services_act_2003.pdf (Accessed 10 September 2015). See also The Western Cape Ambulance Services Regulations, 2012. <https://www.westerncape.gov.za/text/2012/7/ExtraProv-gaz-7010.pdf> (Accessed 10 September 2015).

⁵⁹ Free State Provincial Health Act, No. 8 of 1999. <http://www.rhap.org.za/wp-content/uploads/2014/05/Free-State-PHA-8-of-1999.pdf> (Accessed 11 September 2015).

⁶⁰ www.hpcs.co.za (Accessed 4 July 2015).

functions.⁶¹ It is the objective of the HPCSA to coordinate the professional boards and to act as an advisory body for such boards. The HPCSA and the professional boards have various objectives and are required to advise the Minister of Health where needed and ensure that investigations of complaints are done and proper disciplinary action is taken where necessary. In this section, the researcher specifically focuses on the regulation of the EMS by the HPCSA and the Professional Board for Emergency Care. The objects of the HPCSA and the professional boards will have a considerable overlap, which is indicative of the fact that the professional boards are an extension of the HPCSA that can be seen as the executive regulatory body.⁶²

In a nutshell, the different boards exercise control over the profession that are within their domain. Members of the boards are nominated and selected by members of that specific profession and then appointed by the Minister of Health. The professional boards are responsible for the following:

- Developing policy documents to guide the profession.
- Evaluating education and training courses and academic facilities.
- Recognizing courses for registration and additional qualification purposes.
- Formulating regulations and rules.
- Presiding over professional conduct inquiries.⁶³

The professional boards will also report back with the latest news and developments pertaining to that specific profession.

The Professional Board for Emergency Care was established in terms of the regulations relating to the Constitution of the Professional Board for Emergency Care contained in Regulation No. R 1254 of 28 Nov 2008.

The following professions are registered under the umbrella of the Professional Board for Emergency Care:

- Basic Ambulance Assistants (BAAs)
- Ambulance Emergency Assistants (AEAs)

⁶¹ Carstens & Pearmain (2007) 251.

⁶² *Id* 252.

⁶³ *Behind the scenes*. The Bulletin 2013. HPCSA. 54,55

- Operational Emergency Care Orderly
- Paramedics
- Emergency Care Technicians (ECTs)
- Emergency Care Practitioners (ECPs)

As mentioned earlier, the HPCSA and the Department of Health wants to phase out short course training which includes the BAAs, AEAs and CCAs, which falls under Paramedic, and only provide for ECAs, ECTs and ECPs. The Ndip course however has already been stopped. Thus, all future qualifications will be in the form of formal higher education programs that are aligned to the NQF.⁶⁴ These changes will be in line with the Department of Health and the HPCSA plans for progressing the profession. The ECP degree will still be continued at tertiary facilities.

When looking at the education and training of the Emergency Care Profession, the Professional Board are responsible for setting out an accreditation criteria for the different qualifications as well as an evaluation criteria. This is to ensure that institutions wishing to offer any of the different programs are up to standard and will deliver the finest professionals in the EMS.⁶⁵

The Professional Board for Emergency Care sets out the different scopes of practice as well as protocols and capabilities for the different qualifications. This has to be kept up to date at all times (although last updated in 2006) and has to comply with all international standards. It is very clear that the Professional Board plays an important role in ensuring that the specific profession is coordinated and regulated according to the standards set out by the NHA and the HPA.⁶⁶

⁶⁴ *Guidelines for the completion of the portfolio for institutions wishing to offer the ECT and ECP programmes.* HPCSA, Professional Board for Emergency Care. Form 332.

⁶⁵ www.hpcsa.co.za/PBEmergencyCare/Education. (Accessed 1 October 2015).

⁶⁶ *Ibid.*

5.6. Emergency Medical Services Regulations

Recently Dr A. Motsoaledi, the Minister of Health, made regulations in the Schedule in terms of Section 90(1)(m) read with section 43(1) of the NHA. These new EMS Regulations were announced in the Government Gazette dated 8 May 2015. These regulations apply to both the public and private EMS operating in South Africa although still in draft form and not implemented yet.⁶⁷

These regulations apply to any emergency medical service, aero-medical service, event medical service or medical response service and the licensing thereto. This includes the licensing of the service itself as well as all emergency vehicles.⁶⁸

Numerous requirements are set out in the new regulations and it covers every aspect relevant to the EMS, including staff, equipment, vehicles, stations, inspections and liability insurance. An inspection of an Emergency Medical Service includes an inspection of the organisation and management of that Emergency Medical Service, accommodation, care, treatment of patients, registers, clinical records and any other records of patients, staff and vehicles.⁶⁹

An EMS Advisory Committee must advise and make recommendations to the Head of Department (HOD) on matters concerning licensing.⁷⁰ Lastly these regulations attend to the powers of EMS providers, incident management and coordination of EMS and any offences and penalties. Any person who does not comply with these regulations is guilty of an offence and liable, on conviction, to a fine determined by the HOD or imprisonment for a period not exceeding five years or both a fine and imprisonment.⁷¹

Although these regulations have been made it remains to be seen when it will be implemented. EMS have the responsibility to respect patients' rights, and by adhering to these regulations, it can be accomplished successfully.

⁶⁷ Emergency Medical Services Regulations, Government Notice, No. 37689. http://www.gov.za/sites/www.gov.za/files/37869_rg10239_gon585.pdf (Accessed 9 August 2015).

⁶⁸ Emergency Medical Services Regulations, Section 2 and 3.

⁶⁹ Emergency Medical Services Regulations, Section 6.

⁷⁰ Emergency Medical Services Regulations, Section 7.

⁷¹ Emergency Medical Services Regulations, Section 27-29.

Although there are several Acts, legislative bodies and regulations that control and manage the EMS, there are still substantial grey areas when it comes to certain situations that EMS providers have to deal with in their careers, and unfortunately we are in dire need of a regulatory framework that addresses these unique situations adequately in order to give more legal clarity in this profession. This is discussed in more detail in Chapter Three.

6. Emergency Medical Treatment

As seen in the previous section, the Constitution states in Section 27(3) that no one may be refused emergency medical treatment. The Constitution does however refrain from giving a definition of emergency medical treatment or what can be seen as a medical emergency.

The Constitutional Court attempted to give meaning to this term in the *Soobramoney* case. In this case Mr. Soobramoney claimed that he had a right to receive renal dialysis treatment from the Addington Hospital in terms of Section 27(3) and Section 11⁷² of the Constitution. The application was dismissed. On appeal the Constitutional Court held that the right not to be refused emergency medical treatment meant that a person who suffers a sudden catastrophe which calls for immediate medical attention should not be denied emergency services which are available and should not be turned away from a hospital which is able to provide treatment. In Mr. Soobramoney's case, it cannot be seen as a sudden catastrophe because of the fact that he suffers from a chronic illness. The Constitutional Court decided that this was not an emergency. The Court also held that the right not to be refused emergency medical treatment was independent from the right to life and had to be interpreted in the context of availability of health care services. Unfortunately, the Addington

⁷² The right to life. The Constitution of the Republic of South Africa.

Hospital was under-staffed and under-resourced and thus had a policy of only admitting those patients with a good prognosis in a short period of time.⁷³

According to Carstens and Pearmain, the Constitutional Court correctly refused in *Soobramoney* to create a distortion between ordinary health care and emergency medical treatment. Sachs J in the case stated the following:

The special attention given by Section 27(3) to non-refusal of emergency medical treatment relates to the particular sense of shock to our notions of human solidarity occasioned by the turning away from hospital of people battered and bleeding or of those who fall victim to sudden and unexpected collapse. It provides reassurance to all members of society that accident and emergency departments will be available to deal with the unforeseeable catastrophes which could befall any person, anywhere and at any time. The values protected by Section 27(3) would, accordingly, be undermined rather than reinforced by any unwarranted conflation of emergency and non-emergency treatment such as that argued by the appellant.⁷⁴

The court was of the view that a medical emergency is a sudden and unexpected catastrophe and although the treatment that Mr. Soobramoney required was a case of life and death, it did not necessarily constitute emergency medical treatment. The Durban High Court took the view that the appellant did not suffer a sudden unexpected trauma and although he will die if he does not receive the required treatment and it is an emergency in his eyes, it is not the emergency the legislature had in mind in Section 27(3).⁷⁵

A definition of a medical emergency can be found in the Medical Schemes Act 1998.⁷⁶

(...) the sudden and, at time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

⁷³ *Thiagraj Soobramoney v Minister of Health kwazulu-Natal* 1997 (12) BCLR 1696 (CC). [www.imsa.org.za/files/Library/Health%20Case%20Law%20\(9\)](http://www.imsa.org.za/files/Library/Health%20Case%20Law%20(9)). (Accessed 20 March 2015).

⁷⁴ Carstens & Pearmain (2007)163.

⁷⁵ *Id* 164.

⁷⁶ Medical Schemes Act 131 of 1998.

The Constitutional Court in the *Soobramoney* case redefined the concept of medical emergency. It did not give a precise definition, but rather gave a general sense of what emergency medical treatment does not include.⁷⁷ Justice Madala along with Justice Chaskalson defined Section 27(3), and hence a medical emergency, as, “a dramatic, sudden situation or event which is of passing nature in terms of time. There is some suddenness and at times even an element of unexpectedness in the concept of emergency medical treatment.”

This definition leads to several questions and problems. Although chronic illnesses could perhaps come a long way, a sudden setback could be so serious that medical intervention at an emergency department is necessary to save that patient’s life. One could argue that this is not a sudden event which is of passing nature because of the fact that the patient has a chronic illness, but usually a setback in these cases are also sudden although not completely unexpected, and seeing that chronic illnesses do not constitute a medical emergency, it would mean that in these cases it would not be unconstitutional to refuse such a patient much needed emergency medical treatment which could mean the difference between life and death.

Many acute life-threatening medical emergencies involve complications of already diagnosed chronic illnesses, all of which require emergency medical treatment. This definition will exclude patients with potentially serious or life-threatening medical problems from the right to emergency treatment because the condition may not be sudden or unexpected enough.⁷⁸

Although it seems unfair that chronic illnesses doesn’t fall under the ambit of a medical emergency according to the Constitutional Court, it should be kept in mind that if the court had decided to include treatment for chronic illnesses in the scope of emergency medical treatment, it could have created an onerous burden on the private sector, because of the fact that chasing away patients with a medical emergency who are unable to pay, constitutes an infringement of their rights according to Section 27(3). If the private sector had to accompany such a wide range of ‘medical emergencies’ regardless of patients ability to pay, it could have

⁷⁷ Carstens & Pearmain (2007) 330.

⁷⁸ Kramer *No one may be refused emergency medical treatment – Ethical dilemmas in South African emergency medicine*. SAJBL, Dec 2008.

potentially put the private health sector out of business.⁷⁹ Although payment can be sought from those patients after the emergency medical treatment was given, it is unfortunately a reality that a big margin of those cases will consist out of indigent patients.

In a very recent Constitutional Court case of *Oppelt v MEC*⁸⁰, the court concluded that a low velocity spinal cord injury constituted a medical emergency as defined by the *Soobramoney* case. The court had to decide if Mr Oppelt was denied his constitutional right to not be refused emergency medical treatment after a rugby injury that left him quadriplegic. The Constitutional Court held that the Department of Health acted negligently because Mr Oppelt was not operated on within a certain four hour period, which means that he did not receive the crucial emergency medical treatment that could have prevented the permanent damage. In this case it was general knowledge that the injuries the applicant sustained were a dramatic sudden situation which is of passing nature in terms of time. It amounted to a catastrophe and definitely fell under the definition of a medical emergency. Although the majority judgement stated that that specific operation within the four hour period was the emergency medical treatment that Mr. Oppelt was denied, the minority judgement stated that all the treatment Mr. Oppelt received from the moment he was brought into the hospital constituted emergency medical treatment, which he did receive, and the fact that he was not operated on within four hours did not necessarily mean his right not to be refused emergency medical treatment was infringed on, as all the circumstances had to be taken into account.

The NHA also states in Section 5(2) that a health care provider, health worker or health establishment may not refuse a person emergency medical treatment. Unfortunately, there is no definition of a medical emergency or emergency medical treatment in this particular Act.

The Gauteng Ambulance Services Bill defines 'emergency medical care' as,

The rescue, evaluation, treatment and care of an ill or injured person in an emergency care situation and the continuation of treatment and care during the

⁷⁹ Carsten & Pearmain (2007) 162.

⁸⁰ *Oppelt v MEC: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33. Saflii database (Accessed 16 October 2015).

transportation of such patients to or between medical facilities in order to prevent loss of life or aggravation of illness or injury.⁸¹

Another definition that could be considered is the definition of 'emergency care' and 'emergency care situation'. These terms are defined in the regulations defining the scope of the profession of emergency care which were made by the Minister of Health in terms of Section 33 (1) of the HPA. The definition of emergency care is exactly the same as the definition of emergency medical care as composed by the Gauteng Ambulance Services Bills. 'Emergency care situation' means circumstances during which a person is injured or is for some other reason in mortal danger and in need of emergency care.⁸² These definitions are directly applicable on the EMS. It is clear that these definitions are just as broad and vague as the definition of a medical emergency according to the Constitutional Court. In the EMS, it leaves us with several unanswered questions. For example, what is a medical emergency in the pre-hospital setting? Can the EMS refuse to treat or transport a person where there is no medical emergency and if so, when? Will it constitute abuse or misuse of the EMS system if someone calls for assistance for non-emergent situations? Is there a void in the public education of what a medical emergency truly is? Can medical aids refuse to pay for EMS treatment and transportation if it is not medically justifiable? The list goes on and it is clear that a lack of a definition of a medical emergency creates substantial problems in the EMS, ethically as well as practically.

The definition of a medical emergency according to the medical dictionary is, "An acute, unexpected development or situation that endangers life or limb and requires immediate attention." The definition of emergency treatment is, "Treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death."⁸³ Everybody has their own idea of what a medical emergency is. Medically speaking the following situations could be presumed as an emergency: Chest pain accompanied by sweating, nausea, shortness of breath and radiating pain that moves to the arm or neck or a feeling that your heart is beating too fast; choking;

⁸¹ Gauteng Ambulance Services Bill Notice 2229 in PG 124, 8 May 2002.

⁸² *Regulations defining the scope of the profession of emergency care*. Government Notice R48 in Government Gazette 23040 of 25 January 2002. Health Professions Act 56 of 1974.

⁸³ <http://medical-dictionary.thefreedictionary.com/emergency>. (Accessed 10 October 2015).

severe bleeding; broken or displaced bones; severe burns; difficulty in breathing; suddenly not being able to walk or move a certain part of the body; poisoning; fainting or losing consciousness for an extended period of time; any spinal or head injuries; and severe dehydration.⁸⁴ This is just a quick summary of the most common situations that fall under the ambit of a medical emergency according to those medically trained. A few examples of non-emergencies are: Cold or flu symptoms; muscle sprains; toothache; minor cuts or abrasions; hyperventilation and normal nausea or vomiting.⁸⁵ When a minor injury strikes it is best to seek treatment at your nearest pharmacy or GP. Sadly, the reality is that emergency departments and the EMS often deal with these issues where their primary focus is to assist the critically injured.

In the USA, there is an *Emergency Medical Treatment and Labor Act*, also known as EMTALA. EMTALA is: “A federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay.”⁸⁶ Any Medicare-participating hospital (private hospitals) with an emergency department has to provide a medical screening examination when a patient needs medical treatment for a medical emergency, including active labour, regardless of an individual's ability to pay. Hospitals are then required to stabilise patients and if they are unable to stabilise the patient because of resource restraints, or if the patient requests, a transfer should be arranged.⁸⁷

The definition of ‘Emergency Medical Condition’ provided under the statute is,

- A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - (ii) serious impairment to bodily functions, or

⁸⁴ Medical Emergencies <http://Lexington.wakehealth.edu/Services/Emergency>. (Accessed 10 October 2015).

⁸⁵ *Ibid.*

⁸⁶ Emergency Medical Treatment and Labor Act 1986 (EMTALA). <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/> (Accessed 5 October 2015).

⁸⁷ *Ibid.*

- (iii) serious dysfunction of any bodily organ or part; or
- (B) with respect to a pregnant woman who is having contractions–
 - (i) That there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.⁸⁸

In the EMS, the biggest problem that emanates out of a lack of a proper definition of a medical emergency is the abuse and misuse of the system. Out of practical experience, this is a growing problem and the fact that patient autonomy and patients' rights have become so dominant in relation to their responsibilities is making the situation even more complex. The response to true emergencies can be delayed when there is a constant request for attending to minor incidents that does not even constitute a medical emergency or the need for transportation by ambulance. Ambulance personnel must be relieved of inappropriate requests for an emergency response so that they can deal promptly with patients genuinely requiring emergency care.⁸⁹

As an EMS provider, the researcher has also dealt with various non-emergent calls while working on the ambulance. The worst probably being a call where the patient requested an ambulance for neck pain and added that: "It is probably because of the new pillow that I recently bought." Another frustration is when patients call an ambulance when they have a doctor's appointment but no transport available. This is a problem in most of the medical professions. GPs complain that their expertise is being sought by patients for a range of non-diseases. The British Medical Journal has carried out a survey to find which were the most common. Ageing, boredom, baldness, ugliness, big ears, jet lag and road rage were amongst those.⁹⁰ This is clearly misuse of the medical profession and patients should be reminded that

⁸⁸ *Ibid.* See Also Compliance Of The Social Security Laws, Examination And Treatment For Emergency Medical Conditions And Women In Labor, https://www.ssa.gov/OP_Home/ssact/title18/1867.htm (Accessed 2 October 2015).

⁸⁹ Thakore *et al* *Emergency ambulance dispatch: is there a case for triage?* JRSM. 2002.

⁹⁰ Herring *Medical Law and Ethics*, 2010.

according to the patients' rights charter, patients have the responsibility to utilise the health care system optimally and not to abuse it.

The need for emergency medical treatment arises when a person is faced with the real possibility of death, serious bodily injury or deterioration in health.⁹¹ Every case is unique and has to be treated objectively in order to ascertain if you are dealing with a true emergency or not. It could be argued that personnel working in the EMS should be allowed to legally refuse treatment and transport to hospital in clear non-emergent situations. Montgomery County Maryland Fire and Rescue stated in an article, *A Review of Legal Issues and Recommended Patient Transport Practices*, that in a case where a patient feels that their injury or illness warrants treatment and transportation, but the EMS providers does not feel that the patient needs medical attention, the practitioner should remember that they are not in the business to question the customer's beliefs and must try their best to keep them happy. If the customer does however become a system abuser, the practitioners should document each call as a malicious false alarm and follow the appropriate procedures for handling system abusers.⁹²

Practitioners should err on the side of caution before refusing any treatment even if it is clearly not an emergency. In these cases, not only the law but ethics also play an important part. Health care professionals have a legal and ethical obligation to assist patients, and refusing a patient any form of care based solely on the fact that it does not constitute a medical emergency, is not a clever option. There is no issue in trying to advise the patient to make use of his or her own transport to a local GP after initial assessment, especially if the EMS is provided by a private company and the patient does not have a medical aid and will probably not be able to pay the bill at the end of the day. You as an employee of any private EMS company have the obligation to inform all patients of the associated cost when treating or transporting them to a medical facility. There is a big difference between the private EMS and the Public EMS in these cases. The private EMS consists of private companies which are for-profit organisations. This means that the company will without a doubt suffer

⁹¹ Strauss *Doctor, Patient and the Law* (1991) 91.

⁹² *A Review of Legal Issues and Recommended Patient Transport Practices*. Montgomery County Maryland, Fire and Rescue Service, 1997. <https://www.montgomerycountymd.gov/frs-ql/resources/files/ems/ql/qa/TPMATRIX.pdf> (Accessed 12 October 2015).

financially if EMS providers refuse transport in non-emergent cases and only treat and transport those with true emergencies, as most medical aids cover all treatment and transport by ambulance services. Thus, at the end of the day, EMS providers has to remember that they have to comply with company policy as well as legal and ethical standards in order to escape any form of liability and/or disciplinary action.

Unfortunately, a medical emergency is a term that lacks clarity and is ill-defined. Although a medical emergency is misinterpreted every single day and we are in dire need of a clear definition, health care professionals should let ethics and the fact that they make a promise to assist those in need the day they became a health care professional, lead them into their decision as to treat or not. As frustrating as it may be, nobody wants to be caught in a legal battle or become part of the statistics of unemployment, and thus it is always better to err on the safe side and assist in the emergency as well as the non-emergency situations. In the EMS, personnel are not always able to give an accurate diagnosis without proper assessment in a hospital, and because of this and patients' rights being so dominant in the modern South Africa, it is best to transport those patients with their cold or flu symptoms when they request it.

Because the medical field is so wide and still growing every day, it is extremely complicated to structure a definition of a medical emergency that will be 100% accurate and resolve all of the problems associated therewith. It seems that this will be an issue and a debate amongst legal and medical professionals for years to come. A possible solution to the misuse of the EMS system because of a lack of a definition of a medical emergency, could be better education from a younger age about what could be seen as a medical emergency, by making training in first aid compulsory at all schools as well as tertiary facilities and emphasising how to use the EMS system optimally.

7. Conclusion

Since the introduction of the EMS things have changed immensely for the better. South Africa's EMS consist of qualifications that are capable of handling a very big spectrum of medical emergencies and the EMS profession as a whole, especially the private sector, is growing every day. Paramedics are exposed to extreme situations very regularly and although this is a rewarding career, it is full of frustrations and numerous challenges. The EMS and the pre-hospital environment is a very unique field and because of this it is filled with a tremendous amount of grey areas with regards to the law.

The EMS is regulated within the laws of South Africa and this plays a very important part in making sure that the system functions productively and competently. The Constitution, NHA, HPA, HPCSA, EMS regulations and provincial legislation each controls and regulates the EMS and makes sure that private and public sectors are functioning within the law and according to specific standards in order to comply with patients' rights.

It is very clear that the term emergency medical treatment, or rather the lack of a term, affects the EMS directly which leads to ethical and practical difficulties. It is not an easy term to define as the medical field is extremely broad and it is impossible to create a definition of emergency medical treatment or a medical emergency that caters for every situation. Although a better definition will most likely solve some difficulties experienced in the EMS, it will not unravel all the questions and grey areas EMS providers struggle with. At the end of the day, it starts with adequate education with regards to the EMS system as a whole and how it should be used. In other words, the public has to be educated as to what a medical emergency truly is in order to minimize the misuse and abuse of the system.

It seems that the crucial parts of what can be defined as a medical emergency, is the suddenness and unexpectedness of the situation and the fact that it has to pose a serious danger to one's life or health. If the term is defined broader then it will create overcrowded emergency departments with resources that will have to be more thinly

stretched.⁹³ This is still problematic because of the fact that what one person see as a serious or severe injury or illness is not necessary so severe to someone else. The reality is that although a better definition could clear up some issues, there will always be other difficulties and questions that will have to be dealt with when it comes to emergency medical treatment or a medical emergency.

⁹³ Carstens & Pearmain (2007) 162.

Chapter 3

Medico-Legal Issues in the EMS of South Africa

1. Overview

This chapter focuses on and analyses the diverse and unique situations that EMS providers deal with on a regular basis. As mentioned earlier the pre-hospital environment consists of numerous grey areas and EMS providers have to deal with situations that desperately need some sort of regulated framework or guidelines in order to provide more legal clarity. This chapter assesses every situation separately and points out the medico-legal problems it ultimately leads to, while also trying to find answers as to how these situations should be handled to avoid any legal or disciplinary action. Throughout this chapter, the researcher uses practical examples to explain how these different situations could lead to liability and why there is a need for more legal certainty in this branch of the medical profession.

2. Key Medico-Legal Scenarios in the Pre-Hospital Setting

2.1. Protecting Patients' Rights

This section is based on the researchers own practical experience. After more than three years in the EMS, the researcher has come to see various private EMS companies established in Pretoria alone. Because of the multiple EMS services available, the private sector has become very competitive and many companies will go to extreme lengths to survive in this industry, sometimes at the expense of patients. Unfortunately, most patients are unaware of how the EMS system operates

and have little insight as to how an experience on an accident scene and being treated and transported by the EMS should be.

2.1.1. Relationship between EMS Provider and Patient

The relationship between a doctor and patient is discussed in more detail below.⁹⁴ The normal rules of the doctor-patient relationship should be directly applicable on a relationship between EMS providers and a patient in the pre-hospital setting seeing as it is also a relationship between a health care provider and a patient. Thus in the EMS, an EMS provider-patient relationship will be established when an EMS provider undertakes to treat a patient and that patient agrees to be treated by the EMS provider.⁹⁵ If the patient is unconscious, the relationship will be established as soon as the EMS provider treats the patient. This relationship will be created by means of implied consent.⁹⁶ This relationship will end as soon as the patient withdraws consent to be treated or when the treating EMS provider hands over the patient to a nurse or doctor at a health care facility or to another suitable EMS provider. If the patient was handed over to another EMS provider with a higher or lower qualification, depending on the treatment needed, a new EMS provider-patient relationship will be established.

2.1.2. Medical Insured v Non-Medical Insured Patients

Medical insurance play a pivotal part when it comes to the financial status of private EMS companies. It goes without saying that the more patients transported with some sort of medical insurance like medical aids; workmen's compensation; or travel

⁹⁴ See para 2.2.4 above.

⁹⁵ McQuoid Mason & Dada (2011) 166. Here the Doctor-Patient relationship is discussed, but seeing as a Doctor-Patient relationship and an EMS provider-Patient relationship is both a relationship established between a health care practitioner and a patient, the same rules should apply. See also Cele *A Crying Shame*, The Bulletin 2013, HPCSA. <http://www.hpcsa.co.za/thebulletin/2013> (Accessed 9 December 2015).

⁹⁶ *Consent to medical treatment in South Africa*, an MPS Guide. 2013. <http://www.medicalprotection.org/southafrica/advice-booklets/consent-to-medical-treatment-in-south-africa-an-mps-guide> (Accessed 10 December 2015).

insurance, the stronger the company will be financially, and because of this the patient's well-being could easily be put aside to accommodate even more patients with medical insurance or even where the Road Accident Fund (RAF) is applicable. An example of this is when an ambulance service arrives first on scene and within moments before any other service arrives, loads as many patients as possible into their ambulance as more patients will be billed. This is something seen very regularly on MVA scenes and sadly most of those patients do not grasp how unethical and sometimes negligent this is, because in most of those cases the patients in the ambulance will receive little to none treatment on the way to hospital. When it comes to the non-medical aid patients it goes from bad to worse. Most of the small private EMS companies cannot afford to treat and transport non-medical aid patients as it is a struggle to get the patients to pay the bill. Unfortunately in some cases these patients will be left unattended on a scene and they will have to wait for the provincial services to come to their aid or another EMS company willing to assist them.

One of the most shocking stories the researcher has ever heard comes from a colleague who experienced this first hand while working as a student in Johannesburg (JHB). One evening the student and his supervisor working on the response car were called out to an assault somewhere in Joburg's streets. On arrival there were two patients lying on the ground both in a critical state. While the student and his supervisor were each busy assisting their own patient, a private ambulance arrived on scene. The student asked the EMS providers in the arriving ambulance to assist him to load the patient into their ambulance so that he can continue treatment. One of the EMS providers took out a spine board and spider harness and threw it next to the student and the patient and then climbed back into the front of the ambulance. The student then attempted to put the patient on the spine board by himself and eventually asked a bystander to help him load the patient into the ambulance as the ambulance crew did not want to assist him. After the patient was loaded into the ambulance, the student resumed treatment by himself. When he asked the EMS providers still sitting in the front of the ambulance to help him put up an IV line, they told him that they are not going to help him because the patient does not have a medical aid. Shocked about their response, the student continued to try and assist the patient on his own. Moments later and out of nowhere the driver of the

ambulance sped off while the back doors of the ambulance were still open. The student had to hold on for dear life until the ambulance stopped at a provincial hospital where the patient was taken to the Emergency Department. The student had to phone his supervisor, whom was assisting the other patient and went to another provincial hospital, and ask him to pick him up at the hospital where the ambulance dropped him and the patient off.⁹⁷

2.1.3. EMS Regulations

Another evident problem is the fact that various EMS companies do not satisfy the requirements of the EMS Regulations mentioned earlier.⁹⁸ These regulations set out the requirements of an ambulance service. Everything from the application of a license, fees payable and powers of EMS providers to staffing and vehicle requirements are addressed. These regulations set out exactly what equipment has to be present in every ambulance and response car, including minor and major equipment. It also states the requirements of the qualifications of personnel working in the ambulance and response car. Very often on accident scenes EMS providers get an indication of what is going on in other ambulances. Unfortunately very often it is quite clear that some of the ambulances clearly do not meet the vehicle requirements as set out by the EMS Regulations, nor does the staff meet the qualification criteria for personnel working in an ambulance or response car. As mentioned earlier, most patients do not know what these requirements are and will be none the wiser and feel that they are in safe hands once loaded into the ambulance.

It can without a doubt be argued that patients' rights are infringed when ambulance services do not meet the required standards. Very often patient treatment is sub-standard and negligent because the financial well-being of the company is more

⁹⁷ The researcher gained permission from the colleague who was involved in that specific situation, to use the story in this dissertation as an example of patients' rights being set aside by various private EMS companies in order to survive financially. E Brink, ALS paramedic for a private EMS company. 2015.

⁹⁸ Emergency Medical Services Regulations. 8 May 2015.
http://www.gov.za/sites/www.gov.za/files/38775_rg10427_gon413.pdf (Accessed 10 October 2015).

important than the treatment of patients. This problem can only be resolved if inspections by the Licensing and Inspection Authority are done more regularly and if they ensure that licenses are cancelled or suspended if the EMS companies do not meet the necessary requirements.

Patients' rights and patient safety has become extremely dominant in the modern South Africa and EMS companies and personnel should ensure at all times that they adhere to protocols and regulations applicable in order to escape liability. This will include meeting all the standards as set out by the EMS Regulations; obtaining informed consent when possible; respecting patient privacy and confidentiality; assisting patients where there is a duty to act; acting with the same skill and care as a reasonable health care practitioner in the same circumstances; and respecting the relationship established between practitioner and patient until the practitioner-patient relationship subsides. All of the above are discussed in more detail below.

It remains to be seen when the EMS Regulations will be implemented, but this will without a doubt, if implemented effectively, have a tremendous effect on the EMS of South Africa.

2.2. Negligence in the EMS

2.2.1. Test for Negligence

Generally speaking someone acts negligently if his or her actions do not comply with some sort of standard set by law. This standard is the reasonable person standard. This means that someone's actions will be compared to that of the *bonus paterfamilias*⁹⁹ in the same circumstances. The test for negligence or *culpa* is as follow:

Someone acts negligently if:

⁹⁹ Latin term for the reasonable man. See Snyman *Strafreg.* (2012) 217.

1. The reasonable person in the same circumstances would have foreseen
 - a. That the specific circumstances could have occurred or
 - b. That his or her actions could result in the specific circumstances
2. The reasonable person would have taken reasonable steps to prevent the possibility of such circumstances, and
3. The actions of the person whose negligence have to be tested differ from the actions that could be expected of the reasonable person.¹⁰⁰

In the case of *Mitchell v Dixon*¹⁰¹, Innes ACJ stated the following:

A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill and care, he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.¹⁰²

Professional negligence by doctors occurs when a patient is harmed, because a doctor did not exercise the degree of skill and care that is expected of a reasonable competent doctor in the same circumstances.¹⁰³ A person in the medical profession is expected to exercise the same degree and skill as a reasonable competent person in the same branch of the medical profession. Greater skill and care is expected of specialists in their specific field of the medical profession.¹⁰⁴

When considering the reasonable medical practitioner, the courts state that when this principle is applied, the fact that doctors are also human beings and not machines should be taken into consideration.¹⁰⁵ This is clear in the *Buls v Tsatsarolakis*¹⁰⁶ case where a casualty officer missed a fracture and sent the plaintiff home with pain medication. When the injury did not improve, the plaintiff went to see

¹⁰⁰ Snyman *Strafreg.* (2012) 217. See also formulation of test by Strauss *Doctor, Patient and the Law* (1991) 243; Claassen and Verschoor *Medical negligence in South Africa* (1992) 13; Neethling, Potgieter, Visser *Law of Delict* (2014); Carstens *Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesheer op grond van Nalatigheid* (Unpublished LLD Thesis, University of Pretoria, 1996) 144; Van Oosten *Medical Law – South Africa in International Encyclopaedia of Laws* (ed Blanpain) (1996) para 156; McQuoid-Mason *Introduction to medico-legal practice* (2001) 22. See also *Blyth v Van den Heever* 1980 (1) SA 191 (A) 221.

¹⁰¹ *Mitchell v Dixon* 1914 AD 519.

¹⁰² Carstens & Pearmain (2007) 621. See also *Coppen v Impey* 1916 CPA and *Kovalsky v Krige* 1910 CTR.

¹⁰³ McQuoid Mason & Dada (2011) 339.

¹⁰⁴ *Collins v Administrator, Cape* 1995 (4) SA 73 (C). *Ibid.* See also Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 268; Van Oosten *International Encyclopaedia* para 158.

¹⁰⁵ Dutton *The Practitioner's Guide to Medical Malpractice in South African Law* (2015) 90. See also *Van Wyk v Lewis* 1924 AD 438 at 470 and *Mitchell v Dixon* 1914 AD 519 at 526.

¹⁰⁶ *Buls v Tsatsarolakis* 1976 (2) SA 891 (T).

an orthopaedic surgeon whom confirmed a scaphoid fracture. In this case, it was evidence that such fracture took up to three weeks to be visible on X-rays and that it is indeed a very difficult fracture to diagnose. The court held that the casualty officer had acted as reasonable general medical practitioner would have acted in the same circumstances and that negligence had not been proved.¹⁰⁷

2.2.2. Burden of Proof

In civil cases of medical negligence, the burden of proof rests on the plaintiff (the patient). Firstly, it must be proven that there was a duty of care on the part of the medical practitioner and that he or she failed to fulfil that duty. Secondly the test for negligence, as mentioned above, will be applied and lastly it must be proven that the conduct of the practitioner was the legal cause of the outcome.¹⁰⁸ The standard of proof in civil cases is a 'balance of probability'. This means that the plaintiff who has the burden of proof will have to prove that their case or version is more probable. If both parties' version is equally probable, the plaintiff will lose. A duty to care is discussed later in this chapter.

S.A. Strauss and M.J. Strydom made the following statement regarding civil and criminal cases:

Die strafreg is daardie regsgebied wat voorskryf welke menslike gedraginge misdade is en wat die straf daarvoor is...In die deliktereg gaan dit, vereenvoudig gestel, om die vergoeding van skade. Die strafreg beoog primer die beskerming van die openbare belang, die deliktereg die beskerming van die private belang.¹⁰⁹

When a medical practitioner is involved in civil action, they could also possibly, although very unlikely, be subject to criminal investigation and proceedings, if the

¹⁰⁷ Dutton (2015) 90.

¹⁰⁸ Marian *Severe allergies and the law – The case of anaphylaxis*. Current Allergy & Clinical Immunology, Aug 2012; See also *Van Wyk v Lewis* 1924 AD 438 and Carstens and Pearmain (2007) 261,

¹⁰⁹ Strauss and Strydom. (1967) 173.

negligent act led to the death of a patient. Although the burden of proof is much higher (beyond reasonable doubt) in criminal cases, the consequences are more serious as it could possibly mean a jail sentence and a criminal record. It has to be noted that the test for medical negligence in civil cases is the same in criminal cases.¹¹⁰ The Inquests Act¹¹¹ is aimed at investigating the cause of death when a patient has died of unnatural causes in the opinion of a qualified medical practitioner. Investigations into causes of unnatural deaths have to be conducted in terms of the Inquests Act and a magistrate will then decide whether another person's conduct was possibly the legal cause of the patient's death. This does however not mean that the practitioner is guilty and criminally liable.¹¹² The National Prosecution Authority (NPA) still has to decide if there is a *prima facie* case and all the elements of culpable homicide, or whichever crime the medical professional is accused of, has to be proved in court in order for the professional to be held criminally liable and punished accordingly.

As mentioned in the previous chapter, it is required of the HPCSA to ensure that investigations of complaints are done and proper disciplinary action is taken where necessary. In cases where medical practitioners are accused of negligence, the HPCSA will have to investigate the accusations or complaints and act accordingly.¹¹³

The HPCSA can take disciplinary steps against the following unprofessional conduct (this is not a closed list):

- Unauthorised advertising;
- Over-servicing of patients;
- Disclosure of information in regard to patient without his/her permission;
- Incompetence in regard to treatment of patients;
- Criminal convictions;
- Insufficient care towards patients;
- Operational procedure without patient's permission or consent;
- Improper relationships with patients;

¹¹⁰ Carstens and Pearmain (2007) 622. See also *R v Van der Merwe* 1950 (4) SA 124; *R v Van Schoor*. 1948 (4) SA 349 (C).

¹¹¹ Inquest Act 58 of 1959.

¹¹² n 109. See also Schwikkard and van der Merwe *Principles of Evidence* (2002).

¹¹³ n 61.

- Improper conduct of practitioners;
- Excessive fees charged/overcharging;
- Racial discrimination;
- Rude behaviour towards patients;
- Prescriptions to already addicted patients and
- Perverse incentives and kickbacks.¹¹⁴

When the HPCSA receives a complaint, the complaint will be forwarded to the relevant health care professional concerned within seven days where he or she will be requested to reply on that complaint. The complaint as well as the reply will then be sent to the Professional Board concerned for consideration and if the board decides that there are grounds for the complaint, a Professional Conduct Committee will hold a professional conduct enquiry, during which oral evidence is presented, often including independent, expert witnesses. If the committee finds the health care professional guilty, the decision will be final except if the health care professional decides to appeal. A health care professional found guilty of misconduct may receive: A written warning; a fine; be removed from the register; suspended for a period of time; or will have to pay the costs of the disciplinary proceedings. It has to be noted that members of the public who lodged a complaint with the HPCSA, may also pursue civil litigation, as the Committee may not order a health care professional to make financial restitution to the person lodging the complaint.¹¹⁵

2.2.3. Reasonable Competent EMS Provider

In the case of EMS providers the test will be that of the reasonable competent EMS provider in the same circumstances. Because of the different qualifications in the EMS profession, one will have to take into account the specific qualification of the

¹¹⁴ <http://www.hpcsa.co.za/Conduct> - Overview. (Accessed 30 March 2015).

¹¹⁵ <http://www.hpcsa.co.za/Conduct/Complaints> - Complaints (Accessed 30 March 2015).

wrongdoer, in other words if the actions of a BAA¹¹⁶ is being assessed, the test will be the reasonable competent BAA and not an EMS provider in general. It has to be mentioned that the standard of competence required of a new inexperienced health care provider is not less than that of an experienced health care provider.¹¹⁷ In *S v Mkwetshana*¹¹⁸ an intern was found guilty of negligence and culpable homicide because he did not sought advice from a senior practitioner when he was in a position to do so. In this case inexperience was not an excuse.¹¹⁹

Anyone in the medical profession including EMS providers have to exercise the degree of skill and care expected of a reasonable competent professional in their specific branch of the profession, and they should refrain from attempting procedures outside their scope of practice, except in an emergency, in order to avoid any allegations of negligence.¹²⁰ According to the common law, the degree of skill and care is a question of evidence.¹²¹ Generally the courts will be guided by the standards of the relevant branch of the profession and they will not only rely on professional evidence when making a decision with regards to professional standards.¹²²

If an EMS provider that is employed by an EMS Company or the state, acts negligently in the course and scope of his or her employment, not only will the EMS provider be held liable but also the employer. This is known as vicarious liability. Strauss states that for vicarious liability to exist in the medical field, there must be a relationship of superiority where one individual has authority over the conduct of another.¹²³

According to Carstens and Pearmain, the question in the health care context is whether employees who are registered health professionals can incur liability on the

¹¹⁶ A BAA provides Basic Life Support (BLS).

¹¹⁷ Dutton, (2015) 99. See also *Wilsher v Essex Area Health Authority* [1952] 2 All ER 125 at 133 CA and *R v Van Schoor* 1948 (4) SA 349 (C).

¹¹⁸ *S v Mkwetshana* 1965 (2) SA 493 (N).

¹¹⁹ Dutton (2015) 99.

¹²⁰ When a practitioner practises outside of his or her scope of practice in an emergency, it will only be excused if that practitioner does not practice in any form of emergency medicine and thus the emergency fell outside of his or her general scope. If a practitioner is trained in emergency medicine and attends to any emergency, he or she will be liable if any patient was harmed while practising outside of his or her scope of practise. McQuoid Mason & Dada (2011) 340.

¹²¹ *Blythe v Van den Heever* 1980 (1) SA 191 (A). McQuoid Mason & Dada (2011) 339.

¹²² *Castell v De Greef*. 1993 (3) SA 501 (C). *Ibid*.

¹²³ Strauss (1991) 281.

part of their employers by their negligent actions in the scope of their duties.¹²⁴ The *Lower Umfolosi District war Memorial*¹²⁵ case purported to utter a principle that states that no hospital assumes responsibility for the negligence of any member of its staff engaged in professional work, but this has been overtaken by more recent case law such as *Minister van Polisie v Gamble*¹²⁶ and *Minister of Police v Rabie*.¹²⁷ Nowadays the deciding factor is the intention of the parties to the contract and control is only one of the factors to take into account.¹²⁸

An EMS provider will be seen as acting in the course of his or her employment when he or she was treating any patient while on duty. As an employer, you are vicariously liable in the event of a negligence claim arising out of the act or omissions of your employees. The employee is, however, also independently accountable for his or her own professional judgement. Employees should not only rely on the vicarious liability of their employer, but rather also take out their own professional indemnity. Any investigations by the HPCSA will not be covered by employer's vicarious liability, in other words, disciplinary action taken by the HPCSA is directed at the professional alone. The Medical Protection Society (MPS) is a very well-known society that is a protection organisation for doctors, dentists and healthcare professionals. The benefits include access to indemnity, expert advice and peace of mind. The MPS also assists its members in clinical negligence claims and thus it is advisable for medical professionals including EMS providers to join this organisation as they are also independently accountable when legal action is taken.¹²⁹

The pre-hospital environment is not as regulated and predictable as in hospital situations. Chapter Two made it clear that working in the EMS comes with numerous difficulties, and trying to assist a patient in bad working conditions is definitely one of them. These bad working conditions or surroundings do without a doubt complicate certain medical procedures that fall in the ambit of an EMS provider's scope of practice. One example is where paramedics attend to a critical injured MVA victim

¹²⁴ Carstens and Pearmain (2007) 548.

¹²⁵ *Lower Umfolosi District war Memorial* 1937 TPD 31.

¹²⁶ *Minister van Polisie v Gamble* 1979 (4) SA 759 (A).

¹²⁷ *Minister van Polisie v Rabie* 1986 (1) SA 117 (A).

¹²⁸ Carstens and Pearmain (2007) 549.

¹²⁹ MPS Casebook, Vol 20, issue 1, January 2012. www.medicalprotection.org (Accessed 23 September 2015). See also Medical Protection Society, *Introducing MPS*. www.medicalprotection.org/about-mps (Accessed 23 September 2015).

that is trapped underneath the car next to the highway in the middle of the night in rainy conditions. Many medical interventions will have to be done in those specific circumstances while EMS providers are waiting for the fire department to free the patient from the wrecked vehicle. One can just imagine how difficult it must be to put up an IV line or intubate a patient in those conditions. This stands in sharp contrast to assisting a patient lying in the emergency room with all the necessary equipment and staff available. Negligence without a doubt also occurs in the pre-hospital setting and if someone's injuries are worsened by the wrongful and negligent actions of EMS providers, they will have to endure the consequences just like any other medical professional in hospital. If one takes into account the circumstances that EMS providers work in, the question arises if negligence could be expected in certain situations, or rather if a bigger margin of error should be considered when assessing negligence in the EMS setting. Grounds of justification in medical law as well as *Good Samaritan* laws are discussed in Chapter Four.

A practical example experienced by the researcher gives an idea of the type of situations that could transpire in the EMS and possibly amount to negligence if the patient or the family decides to take further action. The researcher and her colleague responded to a call for an elderly female that was unresponsive. On arrival the patient presented pale and sweaty and did not breathe efficiently. The patient was also GCS 3/15, in other words unconscious. The patient had a neck brace on because of a neck fusion that was done just a few weeks ago. The patient was assessed on scene and IV lines and oxygen was put on. The patient was placed on the stretcher and while the researcher's partner explained the situation to the family, the front legs of the stretcher caved in and the stretcher collapsed on the one side right in front of the family. As one can imagine, this was a big embarrassment for the paramedics and it was quite upsetting as the patient had a neck operation done not too long ago. Apologies were made and the patient was loaded into the ambulance, still deteriorating rapidly. The patient was rushed to hospital with lights and sirens while ventilations were given via a bag-valve-mask, with the worried husband following the ambulance. About two kilometres from the nearest hospital the clutch of the ambulance broke and the ambulance came to a standstill next to the road with the critical patient inside. The husband pulled up behind the ambulance and the crew had to explain to him that the ambulance had broken down and the nearest

ambulance will only be there in 10 to 15 minutes. Fortunately the oxygen and fluids started to work and the patient became more responsive. The second ambulance arrived and the patient was taken to the hospital. Luckily for the EMS providers, the patient made a full recovery and the family were very understanding. In hindsight, things could have turned very ugly if the patient had sustained a secondary neck injury because of the stretcher that collapsed or if the patient sustained permanent damage to her health or even died because of the delay after the ambulance broke down. Although on this occasion it was not a case of professional negligence, the patient or the family could have decided to claim damages from the company because of equipment failure which led to permanent injury or death which could possibly have been prevented otherwise. This just illustrates the unique circumstances and variety of situations that could potentially go wrong in the pre-hospital environment which could ultimately lead to liability.

D. Givot, a paramedic with many years of experience and also a defence attorney stated that to protect yourself from negligence, you should simply do the following: Behave in such a way as to protect the patients around you from harm; do not practice outside of your scope; follow all protocols and relevant procedures; and treat all patients with dignity.¹³⁰ This might sound easy, but seeing as medical negligence claims are on a rise, it is still a scary reality that it could happen to anyone, even those who generally act with the utmost caution. Keeping good clinical records of treatment given and procedures followed, is invaluable evidence when facing any complaint.¹³¹ The only reported case law in South Africa involving the EMS is the *Franks v MEC*¹³² case. In the USA it is something that is seen more frequently and the public is without a doubt becoming more and more aware of the potential liability of the EMS.

¹³⁰ Givot *Negligence explained for the EMS professional*. The Legal Guardian. 2007. <http://www.ems1.com/ems-products/consulting-management-and-legal-services/articles/311436-Negligence-explained-for-the-EMS-Professional/> (Accessed 4 February 2016).

¹³¹ *A doctor's duty* – MPS article in February Medical Chronicle. 2014. <http://www.medicalprotection.org/southafrica/for-members/news-centre/news/2014/02/27>. (Accessed 2 Nov 2015).

¹³² *Franks v MEC for the department of health for the Province of Kwazulu-Natal* (2958/02) [2010] ZAKZPHC.

In the *Franks* case, the plaintiff argued that she contracted HIV after being injured in an accident involving a pedestrian. She stated that she was contaminated by the paramedics who treated both her and the pedestrian who was HIV positive and who died on scene. According to the plaintiff the paramedics acted negligently in that they failed to foresee the risk of cross contamination of the blood of one person by the blood of another person. In this case the defendant was found liable for all damages that the plaintiff have suffered as a result of her contamination with HIV.¹³³

P.A Carstens wrote an article on the *Franks v MEC* case and stated that this judgment serves as a reminder to EMS providers to always act with the utmost caution and professionalism at MVA, PVA or any accident scenes for that matter, in order to avoid cross contamination of accident victims with HIV. He also stated that in this case the judgment was based solely on common law principles and that the court should have given some consideration to the regulatory framework applicable on EMS providers as well as provisions of the Constitution¹³⁴. He asked the question whether or not Section 27 of the Constitution¹³⁵ also extends to pre-hospital emergency care by paramedics and if EMS providers could possibly invoke the limitation clause¹³⁶ in the Constitution and advance some form of necessity to escape liability.¹³⁷

¹³³ *Ibid.*

¹³⁴ See the Health Professions Act 56 of 1974 as amended; The Professional Board of Emergency Care; Regulations Relating to the Qualifications for Registration of Emergency Care Practitioners GN R1006 in GG 25235 July 2003; Regulations Relating to the Qualifications for Registration of Emergency Care Practitioners GN R1006 in GG 30393 of 26 October 2007; Regulations Relating to the Specialities and Sub-specialities in Medicine and Dentistry GN R590 in GG 22420 of 29 June 2001); National Health Act No. 61 Of 2003, Emergency Medical Services Regulations, May 2015, Government Gazette No.38775.

¹³⁵ Section 27(3) - Everybody has the right not to be refused emergency medical treatment.

¹³⁶ Section 36 of the Constitution of the Republic of South Africa 1996.

¹³⁷ Carstens *Contamination with HIV on the scene of an accident due to the negligence of paramedical professionals: Challenges for determining legal liability* 7,8. Tydskrif Vir Hedendaagse Romein- Hollandse Reg (THRHR), 73 (4), pp 665-672, See *Franks v MEC for the Department of Health, Kwazulu-Natal* unreported case no 2958/02 dated 20 January 2010. THRHR 2010 (73).

2.2.4. Doctor-Patient Relationship

The law of obligations, which consists out of the law of contract and the law of delict, generally governs the relationship between doctor and patient.¹³⁸ It is important to remember that apart from any contract, the doctor owes the patient a duty of care which means that any treatment should be performed with such skill as to avoid injuring the patient. If not, the patient will be entitled to claim damages for a civil wrong. Thus a doctor-patient relationship, and therefore liability of a doctor to a patient, is not dependent on a contract between the parties or on the patient having given consent.¹³⁹

The doctor-patient relationship refers to the situation where a patient visits a doctor and the doctor agrees to care for that patient and the patient agrees to be treated by the doctor. Both the doctor and the patient enter into a contractual relationship. This contract takes the form of an implied agreement which states that the doctor will diagnose the patient's complaint and treat the patient accordingly and thus a duty of care is established. This duty of care is based on the principle that a doctor will undertake to treat a patient with the care and skill expected of a reasonably competent doctor in the same medical profession. A doctor who fails to treat the patient in terms of the implied contract may be held liable for breach of contract.¹⁴⁰ According to S.A. Stauss and M.J. Strydom, the law does not require any specific formalities with regards to the relationship created between doctor and patient. Such relationship is created by means of consensus between the relevant parties. In cases of serious surgical operations it would be wise to put the agreement in writing.¹⁴¹

“The doctor–patient relationship has been and remains a keystone of care: the medium in which data are gathered, diagnoses and plans are made, compliance is

¹³⁸ Oosthuizen *An Analysis of Healthcare and Malpractice Liability Reform: Aligning Proposals to Improve Quality of Care and Patient Safety* (LLM dissertation, University of Pretoria, 2014) See also Strauss & Strydom (1967) 104; Claassen & Verschoor (1992) 115; Dada & McQuoid-Mason (2001) 5; Carstens and Pearmain (2007) 283; McQuoid-Mason (2008) LAWSA 30.

¹³⁹ Strauss (1991) 3. See also *Correia v Berwind* 1986 (4) SA 60 (Z).

¹⁴⁰ McQuoid Mason & Dada (2011) 166.

¹⁴¹ Strauss and Strydom (1967) 105.

accomplished, and healing, patient activation, and support are provided.”¹⁴² Once this type of relationship is established, legal obligations and duties are created, hence it is important to understand exactly when the relationship begins and when it ends. A health care professional cannot be found guilty of medical negligence if a doctor-patient relationship or rather a health care professional-patient relationship has not been established.¹⁴³ The relationship between an EMS provider and patient has been discussed at the beginning of this chapter.

It seems that the general rules of the doctor-patient relationship will be directly applicable on the EMS. Although the EMS is a unique branch of the medical profession, this will make no difference to the doctor-patient relationship principle when applied to the EMS. It is important for EMS providers to understand that there is a relationship created between them and their patients when they treat them and that this relationship creates a duty of care which should be honored as far as possible in order to escape any form of liability.

2.2.5. Duty of Care

A doctor-patient relationship, and thus the implied contractual agreement, establishes a duty of care. The common law provides that all health care professionals consists of a duty of care regarding their patients and that they should not harm their patients through negligent conduct.¹⁴⁴ The standard of care, which has already been discussed earlier in this chapter, is that of the reasonable competent practitioner in the same branch of the medical profession. When a duty of care is established, a doctor or any other health care professional owes the patient a duty to

¹⁴² Dorr Goold and Liplin *The Doctor–Patient Relationship Challenges, Opportunities, and Strategies*. J Gen Intern Med. 1999 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1496871/> (Accessed 10 January 2016). See also Lipkin *et al The Medical Interview: Clinical Care, Education, and Research*. New York, NY: Springer-Verlag; 1995.

¹⁴³ Schwab *The Physician-Patient Relationship*, A Guide for Health Care Providers in Tennessee, Tutorial 1, Nov 2007. <http://www.Uthsc.edu/medicine/legaledu/UT/factshhets/PhyscianPatientRelationship.pdf>. (Accessed 15 January 2016).

¹⁴⁴ McQuoid Mason & Dada (2011) 173.

provide medical care that falls within the relevant practitioner's scope of practice; to obtain consent before treating the patient if possible; to maintain confidentiality; and to provide continuity of care or to hand over the patient to another competent practitioner's care.¹⁴⁵

According to the Oxford Dictionary, the term 'duty' means to have a moral or legal obligation towards someone or something.¹⁴⁶ In the Biannual Publication of the Emergency Care Society of South Africa, the duty to act in South African Law was discussed. According to V. Voorendyk,¹⁴⁷ a legal duty to act refers to a situation where a health care worker becomes legally obliged to render emergency medical services to a patient who is unable to give consent. The legal duty to act is found in common law as well as statutory sources. The most important common law source used to determine if a legal duty to act existed is known as the *Boni Mores*.¹⁴⁸ This concept "denotes good public policy and proper moral sentiment."¹⁴⁹ Although moral convictions will not necessarily have any effect on legal proceedings, they do form an important part of legal interests, and after the case of *Minister van Polisie v Ewels*,¹⁵⁰ it is safe to say that where a person who could reasonably be expected to act in a certain situation, such as a paramedic with a serious injured patient, fails to act in the light of a legal duty to act, he or she would surely suffer criminal or delictual liability.¹⁵¹ Another source of a duty to act within the common law worth mentioning is prior conduct. This might be when an EMS provider creates a source of danger and fails to eliminate the danger which ultimately causes harm to another. A good example will be where a paramedic or ECP intubates a patient to administer assisted ventilation and then fails to ensure that the endotracheal tube remains correctly inserted and because of this the patient suffers harm.¹⁵²

¹⁴⁵ n 101.

¹⁴⁶ The little Oxford Dictionary of Current English. Oxford; Clarendon Press; 1994.

¹⁴⁷ Victor Voorendyk is an attorney and currently an Emergency Medical Care student at the University of Johannesburg.

¹⁴⁸ Duty to Act in the South African Law, *Sanguine* Volume 3, Issue 2. July-December 2013. 11. See also Neethling and Potgieter *Law of Delict* (2010) 36,55.

¹⁴⁹ Oxford Reference.

<http://www.oxfordreference.com/view/10.1093/acref/9780195369380.001.0001/acref-9780195369380-e-305> (Accessed 5 January 2016).

¹⁵⁰ *Minister of Polisie v Ewels* 1975 (3) SA 590 (A).

¹⁵¹ *Sanguine*, 12. *Minister of Polisie v Ewels* 1975 (3) SA 590 (A).

¹⁵² *Ibid.*

In the case of statutory sources creating a duty to act, Section 27(3) of the Constitution¹⁵³ and Section 5 of the NHA¹⁵⁴ are of importance. These statutory provisions create a duty to act on health care workers of all kinds in cases where someone is in true need of emergency medical treatment.¹⁵⁵

In the Third Edition of S.A. Strauss, *Doctor, patient and the Law*, the duty to rescue is discussed. Although there is technically no legal duty upon a person to rescue another, a duty to rescue may arise from contract. An example would be in the case of a fireman or paramedic. The scope of the duty to rescue would be determined by the terms of the contract. In the recognised case of *Minister van Polisie v Ewels*,¹⁵⁶ the court stated that where the circumstances are such that an omission would be regarded as wrongful by the juristic convictions of society and evoke moral resentment, the omission would correctly be considered as wrongful, and thus if applied to the medical situation, it is quite clear that there would be a legal duty on doctors, nurses and other medically qualified personnel, including EMS providers, to come to the rescue of accident victims.¹⁵⁷

2.2.6. Locality Rule

In *S v Tembani*,¹⁵⁸ a man was convicted of murder after he shot his girlfriend, although an expert testified that if the wound was treated promptly with a laparotomy it would have ensured a 95% chance of survival. In this case, the victim died of Septicaemia in consequence of a gunshot wound through the chest and abdomen. It was clear that the treatment at the hospital was sub-standard and negligent. Mr Tembani even argued that the doctors and medical personnel at Tembisa Hospital were grossly negligent. The Supreme Court of Appeal (SCA) held that where an attacker with murderous intent inflicts a wound that could cause death, the fact that

¹⁵³ The Constitution of the Republic of South Africa 1996, Section 27(3). Everyone has the right to not be refused emergency medical treatment.

¹⁵⁴ NHA, Section 5. A health care provider, health worker or health establishment may not refuse a person emergency medical treatment.

¹⁵⁵ *Ibid.*

¹⁵⁶ *Minister of Polisie v Ewels* 1975 (3) SA 590 (A).

¹⁵⁷ Strauss (1991) 90. See also Strauss (1991) 25.

¹⁵⁸ *S v Tembani* 2006 SCA 151 (RSA).

subsequent medical treatment is negligent, or even grossly negligent, does not relieve the attacker from criminal responsibility. The court also held that it is wrong to impute legal liability on the supposition that efficient and reliable medical treatment will be available to the victim. Such an approach would misinterpret reality, for it presumes levels of service that do not reflect the living conditions of the majority of the country's population.¹⁵⁹

In other words the court stated that the majority of South Africa does not consist of areas where access to reliable and efficient medical treatment can be taken for granted and, thus, negligence and even gross negligence can be expected in our state hospitals. Consequently in a case as this one, a state hospital cannot be held liable where the death of a patient could have been prevented if it were for better and prompt medical assistance.

According to the *Locality rule* the question can be posed whether the standard of care and skill required of a medical practitioner may be predisposed by the 'locality' where he or she is practising. In other words, is the location where that specific medical practitioner practices relevant when assessing his or her professional medical negligence? In the case of *Van Wyk v Lewis*,¹⁶⁰ there were different reactions to this rule. Innes CJ stated that the ordinary medical practitioner should exercise the same degree of skill and care regardless of his or her locality, where Wessels AJ came to the opposite conclusion.¹⁶¹

Many writers¹⁶² support the view of Innes. Gordon, Turner and Price stated that it should make no difference to skill and care required of a practitioner, whether a patient is in Cape Town or on some remote farm in the Kalahari Desert. They stated that there seems to be some sort of confusion between skill and care and the circumstances in which a medical practitioner has to perform the skill and care.¹⁶³

¹⁵⁹ *Ibid*

¹⁶⁰ *Van Wyk vs Lewis* 1924 A.D. 438. Carstens and Pearmain (2007) 636.

¹⁶¹ *Ibid*.

¹⁶² Claassen and Verschoor 18; Gordon, Turner and Price *Medical Jurisprudence* (1953) 112; Strauss and Strydom 268; Van Oosten Encyclopaedia para 160.

¹⁶³ Carstens and Pearmain (2007) 637. See Gordon, Turner and Price (1953) 112.

Carstens and Pearmain stated that in their opinion, a distinction should be drawn between the subjective competence and ability of a medical practitioner, and the objective circumstances of the locality where the medical practitioner is employed. According to them, the fact that an excellent doctor is for example placed/practises in a remote rural area without supporting medical facilities available should be considered when assessing alleged medical negligence.¹⁶⁴

Taking the above into account when the pre-hospital environment is assessed, it could be reasoned that although the EMS providers working in this unique environment are trained to deal with emergencies outside of hospital, the pre-hospital environment as a whole cannot be compared to that of a private hospital, or any hospital for that matter, and thus the environment should also be taken into consideration when assessing EMS providers alleged negligence. In the case of the EMS, the locality will not necessarily be based on a rural area without supporting facilities in comparison with a hospital in Cape Town, but rather a dangerous or hazardous environment, like a mine or a patient trapped somewhere on a cliff or in a burning vehicle, in comparison with a normal in-hospital situation.

If gross negligence can be expected and excused in state hospitals, it could be argued that the same should apply for the EMS. Not only because of the environment that is not nearly as regulated as in hospital situations, but also because of certain education structures in the EMS that do not necessarily meet specific required standards, negligence could occur more frequently than in other medical fields. In the public sector, a lack of equipment or sub-standard equipment leaves EMS providers with little assistance in emergency situations and this too could lead to injury or death that could possibly have been prevented otherwise.

Carstens and Pearmain stated that medical negligence can never be separated from the particular circumstances of a case. This principle is often referred to as 'concrete negligence'. In essence this means that when a practitioner's conduct is assessed with regards to negligence, all the circumstances, including the locality; the facilities

¹⁶⁴ *Id* 638.

available; financial resources; difficult conditions or emergency situations and the nature of the medical intervention have to be taken into consideration.¹⁶⁵

In the recent Constitutional case of *Oppelt v MEC*¹⁶⁶, the Constitutional Court held that the Department of Health acted negligently because Mr. Oppelt was not operated on within a certain four hour period, which means that he did not receive the crucial emergency medical treatment that could have prevented the permanent damage. The minority judgment stated that there was no negligence and that Mr. Oppelt was not denied Emergency Medical Treatment *per se* just because he was not operated on in the crucial four hour period. The minority argued that all the circumstances had to be taken into account and that according to them Mr. Oppelt did receive emergency medical treatment in accordance with the availability of resources at that moment. Cameron J reasoned that the majority placed insufficient weight on the extremely difficult circumstances in which the medical personnel worked on the day of Mr. Oppelt's injury.¹⁶⁷

2.2.7. Imperitia Culpae Adnumeratur

According to this rule, a medical practitioner who engages in treatment that requires a certain degree of skill, training, knowledge and experience, while he or she is aware of the fact that he or she does not consist of such skill, training, knowledge and experience, will be bound by his or her treatment accordingly with regards to medical negligence. Lack of skill alone will not necessarily amount to negligence, but undertaking work requiring a certain expertise without possessing the necessary competence may be negligent.¹⁶⁸ In *Coppen v Impey*¹⁶⁹ this rule was invoked for the first time in South African Law when the court ruled that a physician, who took X-rays

¹⁶⁵ Carstens & Pearmain (2007) 639. See also *R v Meiring* 1927 AD 41,45; Van Oosten *Encyclopaedia* para 161; Carstens LLD thesis 146.

¹⁶⁶ *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33. Saffii database (Accessed 16 October 2015).

¹⁶⁷ *Ibid.*

¹⁶⁸ Carstens and Pearmain (2007) 628. See also Boberg *The Law of Delict* (1989) 346; Snyman (2006) 220; Barlow *Medical Negligence Resulting in Death* (1948) THRHR 173.

¹⁶⁹ *Coppen v Impey* 1916 CPD 309. *Id* 629.

and through his incompetence caused to burn the patient, acted negligent because of his unskillfulness and was rendered liable for damages.¹⁷⁰

In *Durr v Absa Bank Ltd and Another*,¹⁷¹ the court quoted as follow:

The reasonable person has no special skills and lack of skill or knowledge is not *per se* negligence. It is, however, negligent to engage voluntarily in any potentially dangerous activity unless one has the skill and knowledge usually associated with the proper discharge of the duties connected with such an activity.¹⁷²

According to D. Pearmain, all health care professionals are registered with the HPCSA with regards to certain scopes of practice and when a health care professional practices beyond that scope, he or she will be acting against the law with regards to the *Imperitia*-rule. She asks the question whether there are any circumstances where there will be a lawful defence to such illegal acts and whether the right to emergency medical treatment (Section 27(3)) is limited to the training and experience of the health care professional at the scene, or will the health care professional be able to use Section 27(3) as a defence for what would otherwise be an unlawful act?¹⁷³ With regards to necessity, it is submitted that this defence can be used in a situation where a health care professional, with consent, practised out-side his or her scope in order to save another's life if no other more skilled health care professional was available.

There is a constitutional right to life which, it could be argued, a health professional was seeking to uphold in acting outside of his or her scope of practice in an emergency situation. Even, however, where the risk was not to life but to limb there is the constitutional right to bodily and psychological integrity.¹⁷⁴

¹⁷⁰ *Ibid.*

¹⁷¹ *Durr v Absa Bank Ltd and Another* 1997 (3) SA 448 (SCA). Pearmain *A Critical Analysis of the Law on Health Service Delivery in South Africa*. (2004) 867.

¹⁷² *The Law of South Africa*. First Reissue vol 8.1 para 94; Pearmain (2004) 867.

¹⁷³ Pearmain (2004) 869.

¹⁷⁴ Pearmain (2004) 870. See Also Strauss (1991) 34.

It seems that delictual action against a health care professional, whom acted outside of their scope in circumstances where there was no other choice, and the patient consented to the risks of the treatment and the health care professional acted with the same degree of care as would have been exercised by a reasonable person in the same circumstances, will be extremely unlikely and would most probably not succeed if the health care professional's treatment was in harmony with constitutional values. In a case where the patient consented to the risks involved, the *Imperitia*-rule should be defeated by the maxim *volenti non fit injuria*, which is the Latin term for 'to a willing person, injury is not done'. Although in a situation where consent could not have been obtained for whatever reason, the *Imperitia*-rule could not be defeated by the maxim *volenti non fit injuria*. According to D. Pearmain, it remains to be seen how the courts will interpret the right not to be refused emergency medical treatment in practice and the ultimate question is how far these rights will go as justification for a health care professional acting outside of his or her scope of practise when assisting a patient.¹⁷⁵

In the case of EMS providers, this rule also comes into play when EMS providers are faced with an emergency situation where no 'back-up' or ALS is available. The EMS also consists of different scope of practices applicable on different qualifications, but with years of experience, some EMS providers's abilities go far beyond their scope of practice and thus they will be able to perform interventions outside of their scope if necessary. The rules of conduct specifically pertaining to the profession of emergency care, states that a BLS provider, ILS provider and an ALS provider shall not perform professional acts other than those set out in the relevant protocol.¹⁷⁶

The question is whether or not they will be held legally accountable according to the *Imperitia*-rule if something goes wrong while they were treating a patient and performing interventions which they were not trained to do because no one with a higher qualification was available. If it was a true emergency and the patient would most likely have died if the EMS provider who acted out side of his or her scope did

¹⁷⁵ *Id* 871.

¹⁷⁶ Annexure 3, *Rules of conduct specifically pertaining to the profession of emergency care*. Intermediate life support practitioner guidelines, Professional Board for Emergency Care, HPCSA, form 289. 2006.

not treat the patient, but rather decided to wait for back-up, it is difficult to believe that any court would find the EMS provider guilty of negligence based on *Imperitia Culpa Adnumeratur*, regardless of consent. It would be a different situation if that EMS provider decides to take on treatment which he or she is not qualified or trained to do in a non-emergency situation. In a case like that one will expect that the EMS provider will be guilty of negligence according to the *Imperitia*-rule if he or she caused any damage whatsoever while acting outside of his or her scope.

S.A. Strauss correctly stated that when considering the legal implications of emergency medical treatment, the potential liability of the rescuer to the patient in respect of unskillful medical treatment administered in an emergency, comes to mind. The writer mentioned that he knew of no reported case in South Africa where action was brought against a rescuer (doctor or other person who rendered emergency medical treatment) after some sort of disaster or accident occurred, and the principles of our law are such that successful action brought against someone who rendered emergency medical treatment in good faith is very unlikely.¹⁷⁷

2.3. Consent and Informed Consent

Consent means that a patient agrees to accept a health care service after being informed about the nature, effect and consequences of such service.¹⁷⁸ The Constitution states in Section 12(2) that everyone has the right to bodily integrity which includes not to be subjected to medical or scientific treatment or experiments without their informed consent.¹⁷⁹ The concept of informed consent is a strong expression of autonomy and was introduced in South African law in the case of *Richter v Estate Hammann*¹⁸⁰ and secured in *Castell v de Greeff*.¹⁸¹ The Constitution

¹⁷⁷ Strauss (1991) 89.

¹⁷⁸ McQuoid Mason & Dada (2011) 93.

¹⁷⁹ Section 12(2) of the Constitution of the RSA.

¹⁸⁰ *Richter and Another v Estate Hammann*, 1967, (3) SA 226 (C).

¹⁸¹ *Castell v de Greeff* 1994, (4) SA 408 (C).

reflects the rights of patient self-determination and Section 6, 7 and 8 of the NHA codified the doctrine of informed consent.¹⁸²

2.3.1. Obtaining Informed Consent

Most often obtaining consent from a patient is quite a straightforward and basic procedure. Unfortunately, this is not always the case and knowing exactly how to handle these exceptions are both important and complex. The three main requirements for obtaining consent are 1) a competent patient 2) which received sufficient information and 3) whom is giving consent freely.¹⁸³ According to the NHA, it is an offence to treat a patient without their informed consent.¹⁸⁴ There are exceptions to this rule, such as emergencies or where there is a potential risk to the public health. A competent patient is one who can understand and grasp the information relevant to the particular medical decision. A patient's capacity is relevant here and the two components of legally recognised capacity are age and decisional or mental capacity. A patient will have received sufficient information with regards to his or her treatment if the information given explains the diagnosis, treatment and procedures, risks, probability of success, alternative options and the costs applicable in a way and on a level that the patient will truly understand and appreciate. Consent that was given under pressure or duress is invalid. Thus when a patient gives consent it should be without any influence from third parties, including family and friends.¹⁸⁵ Failure to obtain proper informed consent before any health service is provided may result in disciplinary action from the HPCSA or legal action under the common law for breach of the NHA and potentially a civil claim for assault.

A person's decisional capacity plays a very important role with regards to informed consent. Normally a person's capacity will be assessed in terms of age and decisional capacity. The age of full legal capacity in South Africa is 18 years. If

¹⁸² Manyonga *et al* *From informed consent to shared-decision making*. SAMJ, Aug 2014. See also Brits and Le Roux-Kemp *Voluntary Informed Consent and Good Clinical Practice for Clinical Research in South Africa: Ethical and Legal Perspectives*. SAMJ 2012.

¹⁸³ *Consent – the basics*. MPS, Consent series 2013.

<http://www.medicalprotection.org/consentseries/consentthebasics> (Accessed 12 July 2015). See also HPCSA, *Seeking Patients' Informed Consent: The Ethical Considerations*, second edition May 2007.

¹⁸⁴ NHA, Section 7(1).

¹⁸⁵ n 184.

someone is 18 years or older, it can be assumed that he or she has the capacity to make an informed decision regarding his or her health, except if there is reason to believe that they have some sort of mental impairment which will influence their ability to make an informed decision. Children of 12 years and older who are of sufficient maturity to understand the implications of the medical treatment may consent on their own behalf. Children and consent is discussed in more detail below. Decisional capacity refers to a person's ability to make an informed decision based on all necessary information received. If a patient's decisional capacity is in question, a thorough assessment should be carried out. The best way to make sure that a patient grasps all the relevant information in order to make an informed decision, is to explain and convey all the information in a language that he or she will understand and asking questions afterwards to see if the patient truly knows what the treatment or procedure is all about.¹⁸⁶ It is good medical practice to check if the patient understands all the information provided and give the patient a chance to ask questions and seek clarification.¹⁸⁷

When patients lack decisional capacity, for whichever reason, in the absence of an advance directive, someone else has to make decisions regarding their medical treatment. This may be a family member or a person mandated by the patient, while still *compis mentis*, to act as his or her proxy, or a person authorised by law or court order.¹⁸⁸ If the patient is in possession of an advance directive, this document and the wishes of the patient as stipulated in the directive, must be honoured if the instructions and preferences it contains are appropriate to the circumstances. If there is no advance directive, one of the following may make decisions on the patient's behalf: A proxy mandated in writing; a person authorised by law or court order; the patient's spouse or partner; a parent; grandparent; adult child or a brother or sister, in the specific order. If none of the above exists or are available to give consent, the medical practitioner responsible for the patient's care must make use of the 'best interests' principle to decide how to proceed.¹⁸⁹

¹⁸⁶ n 183.

¹⁸⁷ n 179.

¹⁸⁸ *Consent to medical treatment in South Africa*, an MPS Guide. 2013. <http://www.medicalprotection.org/consent> (Accessed 12 March 2016).

¹⁸⁹ *Ibid*. See also Applebaum *Assessment of Patient's Competence to Consent to Treatment* N Engl J Med, 2007.

The most common types of consent are express consent and implied consent. A patient will normally give his or her express consent when the medical treatment or procedure is of an invasive nature or where there are potential risks. This type of consent will usually be recorded in a consent form with the patient's signature. Written consent should always be taken in cases where the medical treatment or intervention is more complex. Implied consent on the other hand, is where a patient's cooperation implies the consent. An example is where a patient holds out his or her arm in order for the medical practitioner to take a blood pressure (BP) measurement or to put up an IV line. The medical practitioner should still explain what they are about to do and why, in order to give the patient an opportunity to refuse the treatment or assessment if they wish to do so.¹⁹⁰ Implied consent is also designed for the unconscious patient, where it will be in the best interest to assist the patient who can at that moment not provide his or her written or verbal consent.

2.3.2. Emergencies and Minors

Consent in an emergency refers to situations where patients are unable to give consent and will experience irreversible damage or face death if medical intervention is delayed. In these cases, treatment should not be delayed in order to obtain consent. A medical practitioner should thus assist in an emergency if the patient cannot consent and they have not previously expressly, implicitly or by conduct refused that service. According to common law, people who assist others in a medical emergency can usually count on necessity to justify their conduct if needed.¹⁹¹ After the necessary emergency medical treatment was given, the medical practitioner has to convey all the relevant information to the patient in order for the patient to decide if he or she would like to continue further treatment. Necessity is discussed in more detail in Chapter Four.

Children under the age of 18 are seen as minors, who are unable to act independently without assistance from their parents or legal guardians. Because of

¹⁹⁰ n 183.

¹⁹¹ n 189.

the evolving capacity of children, there are circumstances where the law gives minors the capacity to act independently and thus make decisions for themselves.¹⁹²

A child of 12 years or older with sufficient maturity is allowed to consent to their own medical treatment or that of their own child. In the case of a surgical operation, children will have to be assisted by a parent or legal guardian. Whether or not a child consists of sufficient maturity, is something that will have to be assessed by the medical practitioner seeking consent. This is not an easy task as there are no specific guidelines to follow to establish the capacity of a child. The child has to understand the benefits, risks and implications of the treatment in order to be seen as a child of sufficient maturity. Where children do not consist of sufficient maturity or are below the age of 12, consent has to be given by a parent or legal guardian, the superintendent or person in charge of a hospital, the Minister of Health, or a High Court or Children's Court. Medical practitioners should consult with a senior colleague if they are not 100% sure about the capacity of a minor. In the case where a parent or guardian will have to pay for the services, they will have to give consent to pay for it, except in cases of emergency or where the procedure or treatment is necessary and in the best interest of the child.¹⁹³ According to Section 28(1)(c) of the Constitution, every child has the right to basic healthcare and according to Section 28(2) the child's best interests are of paramount importance and will be the main concern in any situation regarding the child.¹⁹⁴

In the *Life Healthcare Group and Others v JMS and Others* case,¹⁹⁵ the issue before the court was whether or not the court should authorise medical treatment for a child to preserve the child's life, despite of the parents objection for religious reasons. An important legal principle before the court was Section 129(4)(a) of the Children's Act¹⁹⁶ which states that the parents of a child under the age of 12 years are authorised to consent to the child's medical treatment, but section 129(10)¹⁹⁷ on the

¹⁹² Strode *et al* *Child consent in South African law: Implications for researchers, service providers and policy-makers*. SAMJ April 2010. See also Robinson JA *et al* *Introduction to South African Family Law* (2008)

¹⁹³ Child Justice Act 75 of 2008. Section 129 (1-10).

¹⁹⁴ The Constitution of the Republic of South Africa 1996, Section 28(1)(c) and 28(2).

¹⁹⁵ *Life Healthcare Group (Pty) Ltd and Another v JMS and Another* (34758/2014) [2014] ZAGPJHC 299. Saffli Database (Accessed 12 March 2015).

¹⁹⁶ Children's Act 38 of 2005, Section 129(4)(a).

¹⁹⁷ *Id* Section 129(10).

other hand states that no parent may withhold consent for medical treatment by reason of religious beliefs, unless the parent can show that there are medically accepted alternatives. Section 126(9)¹⁹⁸ of the Act gives the High Court or the Children's Court jurisdiction to consent to necessary medical treatment in any instance where a parent or a person authorised by the Act to consent refuses or is unable to give consent.¹⁹⁹

There were many conflicting rights in this case. The parent's right to freedom of religion against the child's right to life and the best interests of the child had to be taken into consideration. The Court stated that the rights in the Bill of Rights are entrenched but not unfettered and that they may be limited in terms of Section 36 of the Constitution²⁰⁰. The court also referred to the unreported case of *Department of Health v Sepeng*²⁰¹ and the case of *Hay v B and Others*²⁰² where the Courts dealt with similar situations. The Court in the *Life Healthcare Group and Others* case stated the following:

In the *Sepeng* and *Hay* decisions, the court weighed the conflicting rights set out in paragraph 9 of this judgment. The court held that the parents' right to religion is not unfettered, that the right to life is an inviolable right and to the extent that the parents' right potentially violates the child's right to life, it is in the best interest of the child that the child's right to life is protected.²⁰³

The Court also referred to the *Christian Education South Africa v Minister of Education*²⁰⁴ case, where the Constitutional Court held that:

Courts throughout the world have shown special solicitude for protecting children from what they have regarded as the potentially injurious consequences of their parents

¹⁹⁸ *Id* Section 126 (9).

¹⁹⁹ *Life Healthcare Group (Pty) Ltd and Another v JMS and Another* (34758/2014) [2014] ZAGPJHC 299.

²⁰⁰ The Constitution of the Republic of South Africa 1996, Section 36 (Limitation Clause).

²⁰¹ *Department of Health v Sepeng* (Unreported Judgment).

²⁰² *Hay v B and Others* 2003 (3) SA 492 (W).

²⁰³ *Life Healthcare Group (Pty) Ltd and Another v JMS and Another* (34758/2014) [2014] ZAGPJHC 299.

²⁰⁴ *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC).

religious practices. It is now widely accepted that in every matter concerning the child, the child's best interest must be of paramount importance.²⁰⁵

The court in the *Life Healthcare Group and Others* case there for granted the order and the applicant was authorised to administer the blood transfusion to the child as the doctor deemed necessary.

2.3.3. Consent in the Pre-Hospital Environment

In the pre-hospital environment, EMS providers face issues of consent on a regular basis. These situations, without a doubt, differ from situations in hospital. In his article, *Paramedics, consent and refusal – are we competent?*, B. Steer mentioned: "The challenge for paramedics is that unlike the philosopher's lounge or the physician's consulting rooms, the emergency setting has the capacity to undermine prudent decision making about the elements of informed consent."²⁰⁶ Because of the difficulties of the pre-hospital setting, EMS providers can be uncertain whether or not to accept a patient's refusal.

The EMS are called out by family members who wish for their loved ones to be taken to hospital, without realising that the EMS providers hands are tied if the patient does not give consent to be treated or transported to hospital. When EMS providers assess a patient at home or on scene, it is very difficult to determine the mental status of a patient in such a short time in order to make an informed decision. In the EMS, the term GCS 15/15²⁰⁷ is used to describe a patient that is, according to them, 100% *compos mentis* and of sound mind. A patient that is GCS 14/15 is seen as a patient that is confused. If a patient, after assessment, is GCS 15/15, EMS providers can't force him or her to go to hospital or accept treatment. When a patient is GCS

²⁰⁵ *Life Healthcare Group (Pty) Ltd and Another v JMS and Another* (34758/2014) [2014] ZAGPJHC 299.

²⁰⁶ Steer *Paramedics, consent and refusal – are we competent?* *Australian Journal of Paramedicine*. 2007. <http://ro.ecu.edu.au/jephc/vol5/iss1/4> (Accessed 3 November 2015). See also Iserson *et al Ethics in Emergency Medicine* 1995.

²⁰⁷ *Glasgow Coma Scale*. This scale is used by paramedics and other medical professionals to describe the consciousness of a patient. 15/15 Being fully awake and conscious and 3/15 being completely unconscious.

14/15 EMS providers could argue that the patient is not of sound mind and should be treated or transported regardless of his or her wishes because it is in the patient's best interests.

However, it is not nearly as easy as it sounds. In the first place, if EMS providers decide that a patient cannot decide for himself, they should first try their best to convince the patient to give his or her consent and to cooperate, as this will make things less complicated and traumatic. If the patient keeps on refusing, the EMS providers can't pick the patient up over their shoulder and carry them to the ambulance and start treating them. Thus EMS providers will have to seek consent from the family, who by implication gave consent when they phoned for an ambulance, or an authorised representative, and if the patient does not cooperate after the decision was made for them, they will have to contact the police to come and assist them to take the patient to hospital against their will. This is not something that any EMS provider wants to do as it is upsetting to the family as well as the patient and unfortunately the police are sometimes reluctant to assist in these situations and does not arrive at the scene very hastily. If a family member or authorised representative is not available at that time to give consent, treatment should be initiated and an effort should be made to contact the family or representative in order to obtain consent as soon as possible. If contact with the above mentioned is not possible, the patient should be treated under implied consent. If a patient becomes aggressive and a danger to self or others, the EMS providers and police, if present, will have to make use of restraining measures in order to transport the patient to hospital. Although this is a bad experience overall, EMS providers will have to make use of this technique if it is the only option to help the patient. Restraining of patients is discussed later in this chapter.

Secondly, there are cases where there is an extremely thin line between a patient that can be seen as GCS 15/15 and one that you as medical professional feel are not able to make decisions for themselves. In other words, the patient that could, for argumentative sake, be seen as GCS 14.5/15. In these situations it is very difficult to make sure that you deal correctly with the situation in order to avoid any liability. There are no specific guidelines to follow in order to know for sure what steps to take. In practice, EMS providers will ask the patient a few questions and if they give

the correct answers, they will respect the patient's wishes and let them sign a refusal of treatment or transportation document. Ordinarily, if a patient recognises their surroundings and the people around them they cannot be taken against their will, even if you as a medical professional know that this person truly needs medical assistance and is not 100% capable of making a wise decision regarding their health. It is quite clear that in some cases a patient's refusal can be disregarded. This will be when it is obvious that a person is having a distortion of perception and is a danger to self or others. All of these situations are usually very unpleasant as either the patient will feel violated or the family will be left feeling helpless and disappointed. In the emergency setting, it is difficult to accept or ignore a patient's refusal of treatment and no EMS provider wants to think that a patient suffered medically because the refusal was too easily accepted.²⁰⁸

The laws of consent with regards to children are also applicable on the EMS. Dealing with consent issues when it comes to children is an even more challenging situation. In cases where it is clear that a child needs medical assistance, and for some reason the parents or legal guardian refuses EMS providers to treat the minor, it gets very complicated and unpleasant. EMS providers should remember that no law will ever punish them for acting in the best interest of the child, even if the parents or guardian did not give their consent. Although parents have authority over their children, they are not absolute rulers, for their rule is subject to their duty to act in the child's best interest.²⁰⁹ When a minor is 12 years or older, his or her input should also be sought and EMS providers should remember that a child 12 years or older with sufficient maturity is allowed to refuse treatment or transportation. In the pre-hospital setting, EMS providers will have to respect the minor's decision if it is clear that the child is *compis mentis* and has sufficient maturity to understand the risks of refusing medical treatment, regardless of the parents or guardians wishes. Unfortunately, just like in any other medical profession, it is not easy to assess the child's mental capacity and thus EMS providers should be sure of a minor's maturity and age before disregarding the parents or guardians decision. In cases where the minor requests medical treatment or transport and it is not a medical emergency, the consent of the person responsible for the payment of the service will also have to be obtained.

²⁰⁸ n 207.

²⁰⁹ n 193. See also Wallace *Health Care and the Law* (2001).

There are no specific laws or regulations applicable to the pre-hospital environment alone. The general rules of consent and informed consent count for the EMS just as it counts for any other medical profession. Applying these rules and laws regarding consent to the EMS is not easy because of the uniqueness of the pre-hospital setting and the difficult situations EMS providers have to deal with on a regular basis. A set of guidelines specifically drafted for the EMS on how to deal with consent issues in specific situations will help tremendously in order for EMS providers to ensure that they handle each unique situation to the best of their abilities and to make sure that they avoid any form of liability.

The researcher has experienced numerous situations where a patient refuses to go to hospital or receive any medical treatment. Recently a man in his 60's, diagnosed with heart failure and renal failure was at home and started to deteriorate rapidly. He was at a stage where he could not eat and became very dehydrated and weak. His family phoned for an ambulance knowing that he was in dire need of medical assistance. At that stage he has not had a proper meal in more than four days and he was sitting on the couch wasting away, day in and day out. As the ambulance arrived the family told the EMS providers that the patient does not want any assistance and does not want to go to hospital and asked if the EMS providers could force him to go. The family was immediately informed that the patient could not be taken against his will if he was in a state where he could give or withhold his consent. The patient was assessed and it was very clear to the EMS providers that the patient had to go to hospital as he was in a very bad state. The patient refused to be transported from the start. The EMS providers and the family tried their best to convince the patient to cooperate. At that stage, the EMS providers felt that this was one of those cases where there is an extremely thin line between a patient that can make an informed decision for himself and one that was not in a state to make such a decision. This patient was GCS 14.5/15 because of the fact that he could answer certain questions, but still presented a bit confused. It was a problematic task determining this patient's mental capacity. The family felt helpless and the EMS providers struggled to decide if they could possibly take the patient against his will. They phoned a senior colleague and asked for advice over a recorded line. The senior colleague asked three questions to determine what should be done. He asked if the patient knew where he was, he asked if the patient recognised those around

him and he asked if the patient knew who he was, in other words his own name. When the EMS providers answered yes to all three questions he told them that they could not take the patient without his consent. And so another family was left disappointed and the EMS providers left, after a refusal of transport document was signed, knowing that the patient will very likely die without assistance.

As mentioned, the best way for these situations to be addressed in order for EMS providers to have more legal clarity, will be a set of guidelines, formulated by the Professional Board for Emergency Care, which should provide multiple case analyses and how to handle these unique cases in order to act in the most ethical way and to avoid any disciplinary or legal action. It is expected of EMS providers to be competent on a clinical level as well as an ethical and legal one. There is a need for EMS providers to be formally trained in how to quickly and accurately assess a patient's level of competence. Given the difficulties experienced by EMS providers in their environment, they are probably the most important group that needs training in this field. EMS providers must be able to reason under stress situations and make quick decisions that are ethically and legally appropriate.²¹⁰

2.4. Confidentiality

Confidentiality is a duty imposed on health care practitioners to respect and maintain a relationship of trust between patient and health care practitioner, to ensure that all information regarding a patient is kept confidential at all times and that there will be no disclosure of information without the patient's consent or under conditions prescribed by law.²¹¹ The HPCSA views confidentiality as central to the doctor-patient relationship and states that it is a core aspect of trust.²¹² This relates not only to sensitive information, but to all information regarding the patient.

The right to privacy is enshrined in the Constitution in Section 14. It states that everyone has the right to privacy, which includes the right not to have the privacy of

²¹⁰ n 207.

²¹¹ McQuoid Mason & Dada (2011) 88.

²¹² MPS Casebook. Vol.22, Issue 1, 2014. www.medicalprotection.org (Accessed 16 April 2015).

their communications infringed.²¹³ The NHA also makes it an offence to disclose a patient's information without their consent.²¹⁴ Although the privacy of a patient and confidentiality is crucial, these are not absolute rights as there are certain situations that require a health care provider to disclose information, even if it is against the patient's wishes.²¹⁵

The leading case on medical confidentiality is *Jansen van Vuuren and Another NNO v Kruger*²¹⁶. In this case the defendant owed the patient a duty of confidentiality regarding the patient's medical condition. Despite this, the defendant became aware of the HIV status of the patient and disclosed it to third parties and the court held that the plaintiff had suffered an invasion of his rights of personality, particularly his right to privacy.²¹⁷

2.4.1. Disclosure of Information

According to the NHA and subject to the Protection of Personal Information Act²¹⁸, no person may disclose information about a patient unless in one of the following instances: a) where a patient gives consent in writing; b) where a court order or the law requires the disclosure; c) where there will be a threat to the public health if the information is not disclosed.²¹⁹

The HPCSA gives guidance by listing the following principles regarding confidentiality:

- 1) Patients have a right to expect that information about them will be held in confidence by health care practitioners. Confidentiality is central to trust between

²¹³ Constitution of the Republic of South Africa. Section 14.

²¹⁴ NHA. Section 14, 15 and 16.

²¹⁵ Carstens & Pearmain (2007) 948.

²¹⁶ *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A).

²¹⁷ Dutton (2015) 85.

²¹⁸ Protection of Personal Information Act 4 of 2013.

²¹⁹ NHA, Section 14. See also Carstens & Pearmain (2007) 943; Neethling, Potgieter & Visser *Law of Delict* (2005) 313, 321ff; Nell "Aspects of Confidentiality in Medical Law" (LLM thesis 2006 UP); *Jansen van Vuuren v Kruger* 1993 4 SA 842 (A); *C v Minister of Correctional Services* 1996 4 SA 292 (T); *NM v Smith* 2007 7 BCLR 751 (CC)).

practitioners and patients. Without assurance about confidentiality, patients may be reluctant to give practitioners the information they need in order to provide adequate care.

2) Where health care practitioners are asked to provide information regarding a patient, they should: a) Seek consent of patients to disclosure of information wherever possible, whether or not a patient can be identified from the disclosure; b) Anonymise data where unidentifiable data will serve the purpose; c) Keep disclosure to the minimum necessary.

3) Health care practitioners must always be prepared to justify their decisions in accordance with these guidelines.²²⁰

Practitioners should be cautious of disclosing confidential patient information unintentional while having casual discussion in public areas. When discussions are held for informative or educational purposes, practitioners should keep the identification of the patient anonymous as far as possible as discussions of cases which do not identify the patient present no ethical conflict.²²¹

The common law also provides for the right to privacy and confidentiality which may only be breached if the patient consents to the disclosure; disclosure is ordered by court; an Act of Parliament imposes a legal duty to make a disclosure; or there is a moral or legal obligation on a person to make a disclosure.²²² Lastly, the Patients' Rights Charter provides that any information regarding a patient's health or medical treatment, may only be disclosed with consent or when required in terms of any law or an order of court.²²³

In the case of *Tshabalala-Msimang and Medi-Clinic Ltd v Makhanya and others*,²²⁴ the right to confidentiality came in to conflict with the duty to disclose. The Minister of Finance's medical records were obtained in an unauthorised manner and facts thereof were published by the press, known as the respondents in this particular

²²⁰ *Confidentiality: Protecting and Providing Information*. Booklet 10, HPCSA, May 2008. www.hpcsa.co.za (Accessed 10 November 2015).

²²¹ n 217, 89.

²²² *Id.* See also Carstens & Pearmain (2007) 943; Neethling, Potgieter & Visser *Law of Delict* (2005) 313, 321ff; Nell "Aspects of Confidentiality in Medical Law" (LLM thesis 2006 UP); *Jansen van Vuuren v Kruger* 1993 4 SA 842 (A); *C v Minister of Correctional Services* 1996 4 SA 292 (T); *NM v Smith* 2007 7 BCLR 751 (CC)).

²²³ Patients' Rights Charter.

²²⁴ *Tshabalala-Msimang and Medi-Clinic Ltd v Makhanya and others* 2008 3 BCLR 338 (W).

case. The court had to decide whether in this case it was justifiable according to Section 36 of the Constitution to limit the applicant's constitutional right to privacy in order to allow for a disclosure that is in the public's interest and thus also preventing restraining the freedom of the press.²²⁵ P.A. Carstens made the following comment regarding the case,

Undoubtedly the judgment is one of those rare decisions which was apparently welcomed equally by the applicants and the respondents for, while it offers a strict *grundnorm* for the mandatory protection and the maintenance of the privacy and confidentiality of medical records, it simultaneously offers a significant lifeline for freedom of speech and the sanctity of the public interest.²²⁶

On the one hand, the Court acknowledged the fact that the medical records were obtained unlawfully and thus the respondents were to be held accountable but, on the other hand the Court made the ruling that the press, in this case, cannot be stopped in commenting about the applicant, who is a public figure, as the facts of her medical records were in the public's interest. This case just illustrates once again that, although the right to privacy is enshrined in the Constitution, it is not an absolute right.

2.4.2. Confidentiality in the Pre-Hospital Environment

Confidentiality in the pre-hospital environment doesn't come without numerous difficulties. EMS providers learn very sensitive information about a patient in a short time. All information encountered by EMS providers must be treated with respect and kept confidential and information should only be transferred to those who are assuming direct care of the patient.²²⁷

In the pre-hospital setting, it is required of patients to disclose all information regarding their health in order for the EMS providers to be able to treat the patient

²²⁵ Carstens *Tshabalala-Msimang and Medi-Clinic Ltd v Makhanya* 2008 3 BCLR 338 (W) De Jure (2008) 453.

²²⁶ *Id* 461.

²²⁷ Adams *Ethical Challenges in Emergency Medical Services, Prehospital and Disaster Medicine*, 1993. See also Beauchamp TL, Childress JF *Principles of Biomedical Ethics* (1983).

suitably. Patients or their family or friends are required to give as much information as possible in the short period of time while assessing the patient. It could complicate things if certain information is left out and the EMS providers could struggle to diagnose the problem or possibly provide the wrong treatment. Although EMS providers are also obliged to keep all patient information confidential, some patients are reluctant to be open and honest about all their relevant health issues as they feel that they can only have a real trust relationship with their doctor. In the pre-hospital environment, EMS providers are required to present all the information given to them by the patient to the receiving practitioner, which will either be a nurse or a doctor. In most cases it will not only be one nurse or one doctor, as the health care team as a whole will have to be informed about the patient they are assisting and it is the EMS providers duty to make sure that all of the health care practitioners, who will from that point on take over the care of the patient, are aware of all relevant information with regards to the patient's health.

When a health care provider is satisfied that a patient's information should be disclosed, they should act promptly in order to release all the information, especially when it is important in order to protect the interests of the patient or the well-being of others. Patients should be informed by health care practitioners, including EMS providers, that their personal information will be shared with other health care practitioners who will provide continuity of care. Practitioners will not be able to treat patients to the best of their abilities if they do not have all relevant information about a patient's condition and medical history. EMS providers must make sure that the health care practitioner they are handing the patient over to understands that the information is given to them in confidence.²²⁸ Something that also comes to mind when thinking about confidentiality in the pre-hospital setting is how to handle situations where there is more than one patient present on scene or in an ambulance. Although it could be quite difficult and sometimes even impossible, EMS providers should do their best to obtain the patients' medical history without potentially disclosing that information to other patients close by.

Some patients put their entire trust into the EMS providers treating them and are more than willing to disclose everything about their health. In South Africa, numerous

²²⁸ n 220.

patients will disclose their HIV status to the EMS providers when they ask about their medical history. The question is if an EMS provider is allowed to disclose that information along with all other information when handing over a patient, without asking the patient's consent specifically with regards to their HIV status? Does the EMS provider have a moral or legal obligation to disclose that information to the nurses and doctors or do they first have to seek consent from the patient? Is the HIV status of the patient something that has to be dealt with differently than other medical information or problems pertaining to the patient?

According to the MPS, the HIV status of patients should always be treated as extremely confidential. The HPCSA gives guidelines on how to treat a patient's HIV status and states that confidentiality regarding a patient's HIV status extends to other medical practitioners. Health care professionals may not inform other health care professionals about a patient's HIV status without the patient's consent unless it is clinically indicated. If the disclosure of a patient's HIV status is in their best interest when it comes to treatment and care, this should be explained to the patient.²²⁹ The HPCSA also states that due consideration should be given to other health care professionals that will interact in some or other way with the treatment and care of a HIV positive patient. In other words, informing other health care professionals of the patient's HIV status with the patient's consent.²³⁰

2.5. Legal Documentation

Legal documentation forms part of any medical profession and is an integral part of patient care. When any questions arise about the treatment of a patient in and out of hospital, patient records can give answers to those questions. Health care practitioners deal with hundreds and thousands of patients throughout their careers and it is impossible to remember details about those patients' history and treatment. Thus, it is crucial to be very thorough when constructing patient records. One will

²²⁹ *Ethical Guidelines for Good Practice with regard to HIV*. HPCSA. 2008 para 5. <http://www.hpcsa.co.za>

²³⁰ *Id* para 4.

have to go back to the patient record if any issue rises regarding consent, confidentiality, negligence allegations, disciplinary actions or any legal litigation. Records are therefore kept for continuation of care, clinical audit, research and evidence in litigation.²³¹

2.5.1. Requirements of Patient Records

Patient records should contain as much information regarding the patient as possible. A good patient record will contain identification of the patient; times and dates; medical history; any observations made; treatment given including medication and the amounts; reaction to any treatment or medication; proof of consent; handover details; practitioner details; patient's condition throughout; signatures; next of kin details and any other additional notes that should be mentioned.²³² EMS providers should always keep in mind that these records are confidential and should not be handed out or shared with anyone but the receiving practitioners that will continue care. It is good practice to keep the original document and store it, according to the company's legal policy, and only give a copy to the relevant practitioner resuming care. Records should be stored in a secured place in order to keep them confidential but still accessible. According to law, medical records should be stored for six years after not being used. In cases of minors, it has to be stored until they are 21 years old and in cases of psychiatric patients, until they have passed away. With Injury on Duty (IOD) patients, records should be kept for 20 years.²³³

Although EMS providers own the records because it was produced by them, patient records have to be accessible to the patient, all treating practitioners and the courts.²³⁴ A health care practitioner may make available a patient's records to a third party without consent of the patient where a court orders it; where a third party needs

²³¹ *Guidelines on the keeping of patient records*. Booklet 14, HPCSA. May 2008. <http://www.hpcsa.co.za>

²³² *Id* para 4.

²³³ *Id* para 9.

²³⁴ *Id* para 10.

the records to mount a defence in court or at disciplinary proceedings; where there is a statutory obligation to disclose certain facts and lastly where non-disclosure of medical records will be a serious threat to the public health.²³⁵ When any changes are made to patient records, nothing should be removed out of the document. With paper based documents, changes should be crossed out and the new information should be written next to it with the relevant EMS provider's signature. In the case of electronic documents, the changes should not be deleted, but rather kept there with the new alterations and an explanation for the changes made. The date when any changes were made or new information added should also be visible next to it.²³⁶ It is best to do it this way as questions could be asked with regards to any information that has been erased or deleted. It is important to make clear notes when writing patient records in order to be able to recall clearly what had happened if the patient's treatment comes into question. In litigation cases, it can take more than two years for a court case to begin, and because of this it is essential to have detailed and clear patient notes.

2.5.2. Case Law

In the *Kitching v Premier of the Eastern Cape Province*²³⁷ case, the court had to decide whether the plaintiff suffered damages because of the negligence of the treating hospital, or on the scene of the accident. The patient record form produced by the ambulance crew was not 100% completed which made it difficult to know if the plaintiff was paralysed on scene or only because of substandard treatment at the hospital. Clear and thorough case notes made by the ambulance crew, could have made it more obvious as to when the paralysis occurred along with other injuries. Vital signs, especially the blood pressure can be an important indicator in determining whether a patient is suffering from neurogenic or haemorrhagic shock, and in this specific case it could have played an important part in determining if the plaintiff's spinal cord was compromised prior to his admission to hospital. It was only

²³⁵ *Id* para 11.

²³⁶ *Id* para 8.

²³⁷ *Kitching v Premier of the Eastern Cape Province Supra*.

observed by a doctor a few hours after the plaintiff's assessment and initial treatment in hospital that the plaintiff could not move his toes. There was also nothing mentioned in the patient record of the ambulance crew about any neurological outfall. This could also have played a pivotal role if it was clear that with initial assessment on scene there were no indications of spinal injuries. In this case, the treatment of the paramedics was not in question and they did not form part of the defendants, but this case does however prove how imperative thorough patient notes are and what role it can potentially play in litigation.²³⁸

2.5.3. Refusal of Treatment/Transportation Documentation

With refusal of treatment or transport documentation, EMS providers should ensure that they write down all the details from the time of arrival up until the refusal was signed. Refusal of Hospital Treatment (RHT) documents are very important in cases where an EMS provider feels that the patient needs medical assistance and transport to a hospital, but the patient refuses. Where it is clear that the patient does not have any injuries it could be argued that a RHT document does not have to be signed. According to The County of San Mateo EMS, neither a Patient Care Record (PCR), nor Refusal of Services Release (RSR) is required when a patient does not demonstrate any suspected illness or injury and who has not been subjected to a significant mechanism of injury.²³⁹

If a patient refused medical assistance and something happens to that patient afterwards, the chances are quite good that fingers will be pointed at the EMS provider that accepted the refusal. Because of this, it is important that an EMS provider can produce a detailed document that proves that the patient did not want any medical assistance even after it was advised. EMS providers should make a note that all risks of refusal was explained and that the patient was mentally capable to understand these risks. If the patient was assessed before the refusal, all vital

²³⁸ *Ibid.*

²³⁹ *Refusal of care and/or transportation.* County of San Mateo EMS. Dec 31, 2004. http://www.smchealth.org/sites/default/files/docs/EMS/EMS_Ops_21_Refusal_of_Care_Transport_2014_10_1.pdf (Accessed 12 February 2016).

signs and observations made should be written down. Preferably the patient should sign the document with a third party signing as a witness. If the patient refuses to sign the document or is incapable to sign, this should be mentioned in the RHT document with a witness signing next to it. In cases where the EMS provider feels that it is a case as mentioned earlier, where there is a thin line between a patient's refusal that can be accepted and one where you as EMS provider are not sure if the refusal should be accepted, it is even more crucial to make very detailed notes about the case, and make sure the patient or a family member signs as well as a reliable witness.

D. Givot mentioned in his article, *Non-transport PCR: Choose either thorough documentation or saving for a lawyer*²⁴⁰, that civil and some criminal courts across the USA, are flooded with cases alleging malpractice, negligence and even abandonment by EMS providers arising out of calls where the patient was not transported, and whether transport was necessary is only a secondary issue. He also stated that poor documentation is a common element in cases where the provider is found liable.

It is crucial to ensure that RHT documentation is thoroughly completed and contains all the applicable information for that specific situation and patient. When an EMS provider asks a patient to sign the RHT document, they should make sure that the patient knows and understands what he or she is signing. These documents are the only proof of what exactly occurred on that specific date and time. Unfortunately most documentation, specifically RHT documentation, is insufficient and lacking in detail. An investigation was done by R. Spicer and S. Sobuwa at the Department of Emergency Medical Sciences at Cape Peninsula University of Technology on whether patient record forms, as currently completed, meet minimum legal standards and provides medico-legal protection to pre-hospital providers. In this study, not one case report accomplished 100% compliance with legal standards. It is quite clear that documentation is very poorly understood by EMS providers and this could possibly lead to grounds for litigation. A common saying regarding documentation is,

²⁴⁰ Givot *Non-transport PCR: Choose either thorough documentation or saving for a lawyer*. The Legal Guardian, 2015. <http://www.ems1.com/ems-products/ePCR-Electronic-Patient-Care-Reporting/articles/2150321-Non-transport-PCR-Choose-either-thorough-documentation-or-saving-for-a-lawyer/> (Accessed 10 October 2015).

“If it was not documented, it was not done.”²⁴¹ This is a good principle to follow and EMS providers should always ask themselves, when completing any documentation, if they will feel confident when they have to use that documentation to defend themselves in a legal battle. At the end of the day documentation is the only lasting proof of what has been done during the treatment of patients.²⁴²

The County of San Mateo EMS gave guidelines as to the process that should be followed when completing any RHT documentation in order to ensure that the EMS providers will be covered if taken to court. This will constitute best practice and EMS providers should take the time to make sure that their RHT documents are according to legal standards.

- Determine that the individual meets the definition of a patient and is competent to refuse care and sign the Refusal of Service Release Form.
- Clearly offer both treatment and transportation to the hospital and document on the PCR. (Patient Care Record)
- Attempt to perform a physical assessment that includes a complete set of vital signs and document on the PCR.
- Obtain and document a history of the event. When possible include prior medical history including medications and document on the PCR.
- Explain the risks of refusal of medical treatment and/or transportation and document the explanation given on the PCR.
- Explain the benefits of medical treatment and transportation and document the conversation on the PCR.
- Determine and document that the patient has an understanding of the risks and benefits of treatment and transport.
- Prepare and explain the Refusal of Services Release Form to the patient or the patients designated medical decision maker.
- Have the patient or the patient’s legal representative sign the Refusal of Services Form.
- The signature of the patient or the patient’s representative should be witnessed if possible.

²⁴¹ *An analysis of the validity of medico legal documentation in cases where the patient refuses treatment and/or transport.* R Spicer & S Sobuwa, SAJBL, Vol 7, No 2, 2014.

²⁴² *Ibid* See also Levy, Mareiniss and Lacovelli *The importance of proper against-medical-advice (AMA) discharge: How signing out AMA may create significant liability protection for providers.* J Emerg Med 2012.

- The paramedic should attempt to have a preferred witness sign the Refusal of Services Release.
- Should the patient refuse to sign the Refusal of Services Release two individuals who witnessed the interaction should sign the Refusal of services Release Form and there should be documentation of the circumstances surrounding the refusal of service on the PCR.
- Advise the patient or the patient's legally designated medical decision maker to seek medical attention for complaints and document on the PCR.
- Advise the patient or the patient's legally designated medical decision maker to call 911 if the condition worsens and document on the PCR.
- Determine whom if anyone will be present with the patient and document on the PCR.
- Physician contact is not required but the base hospital physician should be consulted as needed for any difficult case."²⁴³

These are great guidelines to follow in order to ensure that all bases are covered and that the EMS providers can be confident if any questions arise about the refusal of treatment and/or transportation. A type of checklist that can be used in difficult situations regarding refusal of treatment could be a helpful tool for EMS providers.

2.6. Do Not Resuscitate Orders (DNR's)

Do Not Resuscitate (DNR) orders can undeniably be regarded as one of the greyest areas of all medico-legal issues in the EMS. In the pre-hospital environment it is extremely difficult to know how to handle a situation where a DNR order comes into play, especially when it is expected of EMS providers to act quickly and effectively in serious medical emergencies. Out-of-Hospital DNR orders have been implemented by various states in the USA from as early as the 1980's, which, without a doubt,

²⁴³ n 239 para 6.

transferred ethical and legal difficulties from the emergency room to EMS providers in the pre-hospital environment.²⁴⁴

2.6.1. Futile Treatment

In A-Z of Medical law, a DNR order is defined as: “Instructions by doctors to health professionals not to resuscitate patients who require CPR in order to save their life in situations where attempts to apply CPR to them would be futile”²⁴⁵

Health care professionals are not obliged to engage in futile treatment. Futile means that the prognosis is hopeless. The definition of futile medical treatment according to the World Medical Association (WMA) is, “Treatment that offers no reasonable hope of recovery or improvement or from which the patient is permanently unable to experience any benefit.”²⁴⁶ Because of this patients could be subjected to a DNR order regardless of their wishes or those of their relatives.

2.6.2. Right to Refuse CPR

There is no legislation in South Africa that governs the use of DNR orders. It is argued that, because a mentally competent patient can refuse medical treatment, even if it will lead to his or her death, a patient should also be able to consent to or refuse CPR. Thus in cases of DNR orders, the general principles of informed consent apply. Although CPR should be seen as the rule and DNR as the exception, it is important to understand the rules applicable to DNR orders, as disregarding a patient’s wishes concerning medical treatment could be an infringement on his or her constitutional rights. A patient that requests a DNR order will have to discuss it with

²⁴⁴ Geppert *Saving Life or Respecting Autonomy: The Ethical Dilemma of DNR Orders in Patients Who Attempt Suicide*. The Internet Journal of Law, Healthcare and Ethics. 2010. See also Adams *Prehospital do-not-resuscitate orders: a survey of state policies in the United States*. Prehosp Disaster Med. 1993.

²⁴⁵ McQuoid Mason & Dada (2011) 205.

²⁴⁶ McQuoid-Mason *Medicine and the Law*, SAMJ 2013. See also World Medical Association. Handbook of Medical Ethics.

his or her doctor who will in return consult with the family, the patient and the medical team. All the necessary documentation will have to be signed and once the DNR order is issued, it will be binding on all health care professionals, including EMS providers.²⁴⁷ Although technically DNR orders are applicable on EMS providers and the pre-hospital environment, in practice in South Africa at this stage, DNR orders are only used in hospitals and thus the massive lack of research and guidelines on out-of-hospital DNR orders in South Africa.

2.6.3. DNR Orders in the Pre-Hospital Environment

In the EMS setting, DNR orders are complex because time is so limited and the situations in which it becomes relevant can sometimes be described as unexpected and chaotic. When a patient collapses and family, friends or bystanders call the emergency services, and upon their arrival they are informed that the patient has a DNR order, it complicates the situation tremendously. Usually in those cases prove of the DNR order will not be available, or if the documentation is available, the EMS providers will not be sufficiently trained to know what exactly to look for in order to confirm if the DNR order is valid and should be respected or not. There are several questions with regards to DNR orders. A few questions the researcher asks out of practical experience are as follows:

- What treatment falls under a DNR order?
- Is a DNR order only applicable on patients in cardiac arrest or is intubation without compressions also not allowed?
- What do you need to look for in order to confirm if a DNR order is valid or not?
- Should CPR be initiated until the DNR order is confirmed?
- Does a living will have to include a DNR order in order for CPR to be withheld pre-hospitally?
- Does a DNR order have to be renewed from time to time?

²⁴⁷ n 246.

- What should be done if the patient has a DNR order but the family insists that CPR should be performed?
- Can a healthy person request a DNR order or is it only applicable in cases where CPR would be futile?
- And lastly, is a DNR order only applicable on natural deaths and would a suicide attempt thus nullify a DNR order?

These are all questions that do not have clear straightforward answers, but are very important aspects in the pre-hospital environment that should be addressed.

The SAMJ stated when a DNR order should be respected:

DNR orders may be initiated: (i) where a patient has made an advanced directive or makes an informed decision to refuse CPR; (ii) when clinical judgement concludes that CPR would be futile because it would not restart the patient's heart and breathing and restore circulation; and (iii) when after discussion with the patient and/or his or her family an agreement is reached that the benefits of CPR are outweighed by the burdens and risks involved.²⁴⁸

A DNR order is written by a doctor, following a patient's wishes in an advanced directive or an informed refusal by the patient or his or her representatives. A living will is a type of advance directive made by a mentally competent patient that states that if the person suffers from an incurable disease or is injured in an accident and the prognosis is hopeless, he or she does not want to be kept alive by artificial means. A living will can be interpreted to include a DNR order or the patient can include a clause requesting a DNR order. Living wills are also not recognised by statute, and are just like DNR orders, based on the common law principles of informed consent.²⁴⁹ Advance directives can be helpful in ascertaining patient wishes with regards to end of life decisions, but a standard advance directive does not address resuscitation issues in the pre-hospital environment.

²⁴⁸McQuoid-Mason *Emergency medical treatment and 'do not resuscitate' orders: When can they be used?* *Medicine and the Law*, SAMJ 2013. See also *Decisions relating to Cardiopulmonary Resuscitation*. British Medical Association, Resuscitation Council (UK) and Royal College of Nursing London: BMA, Resuscitation Council (UK) RCN, 2002 para 10.

²⁴⁹*Ibid*. See also McQuoid-Mason and Dada (2011); and South African Law Commission. Draft Euthanasia Act. Pretoria: SA Law Commission, 2004:54.

The HPCSA provides guidelines on end of life decisions and withholding and withdrawing of treatment, but these guidelines are more based on in-hospital situations as opposed to the pre-hospital setting.²⁵⁰ There is no policy or specific guidelines for out-of-hospital DNR orders, nor any out-of-hospital DNR order forms, which leaves EMS providers with very little legal clarity on this specific topic. In an article from the American College of Emergency Physicians, *Do Not Attempt Resuscitation Orders in the Out-of-Hospital Setting*, it was stated that to ensure maximum consistency and compliance, a comprehensive out-of-hospital Do Not Attempt Resuscitation (DNAR) policy should be endorsed and whenever possible it should be recognised by legislative measures. This article provides an excellent example of what an out-of-hospital DNR policy should consist of.²⁵¹ The most important aspects are highlighted.

The Out-of-hospital DNAR policy should:

1. Note the established fact that current basic and advanced life support interventions may not be appropriate or beneficial in certain clinical settings;
 - **Develop a means to educate the public about the appropriate use of 911 following expected deaths.**
 - Establish the fact that comfort care and palliative care are affirmative actions for patients with DNAR orders. These appropriate interventions, (e.g., hospice or respite care) DO NOT require EMS activation, and often can be arranged by calling the patient's physician in anticipation of death.
 - **Develop a means to educate healthcare workers on topics of Advance Directives, including information on local out-of-hospital DNAR, community hospice alternatives, and bereavement services.**
2. **Establish consensus on the ideal identification device for DNAR directive to assure continuity of care across settings;**
3. **Reiterate that initial resuscitative attempts are usually indicated when the patient's wishes are not known;**

²⁵⁰ *Guidelines on the Withholding and Withdrawing of treatment.* HPCSA. Booklet 12. <http://www.hpcsa.co.za> (Accessed 5 November 2015).

²⁵¹ *Do Not Attempt Resuscitation Orders in the Out of Hospital Setting.* American College of Emergency Physicians. <http://www.acep.org/Clinical---Practice-Management/-Do-Not-Attempt-Resuscitation--Orders-in-the-Out-of-Hospital-Setting/> (Accessed 10 December 2015).

4. **Define the conditions under which an out-of-hospital DNAR order can be considered; including its use in long term care settings and in the emergency department.**
5. Define which patients have the decisional capacity to agree to a DNAR order and whether surrogates can sign such orders.
6. Establish a mechanism for determining the precedence of various directives (e.g., Living Will, Durable Power of Attorney for Healthcare, Out-of-Hospital Advance Directive (DNAR)).
7. Develop a statutory prioritised list of surrogates to use when there are no advance directives and the patient's decisional capacity is impaired.
8. Consider language acknowledging the growing home hospice movement as concern children and incorporate provisions for document use in minors.
9. Establish that the decision not to attempt resuscitation must be an informed decision made by the patient or surrogate;
10. **Identify the information that should be contained in the DNAR order and the authority that will be responsible for developing such a mechanism;**
11. **Identify the clinical procedures that are to be provided and those withheld in the adherence with the DNAR order, or specify which authority will verify adherence.**
12. Define the exact manner in which the DNAR order is to be followed, including the role of on-line medical direction. Each system should ensure that a communication path to access on-line medical direction is immediately available, when necessary.
13. **Establish legal immunity provisions for those who implement DNAR orders in good faith.**
14. Establish data collection and protocol evaluation to perform periodic operational assessments;
15. **Identify permissible exceptions to compliance with DNAR out-of-hospital directives. For example:**
 - **The patient is able to revoke a written directive at any time.**
 - **The EMS providers can cancel the out-of-hospital DNAR order if there are doubts about the document's validity.**
 - **The EMS providers can provide CPR if it is necessary for provider safety.**
16. Out-of-Hospital DNAR policy should also include a mechanism for ensuring the proper pronouncement of death, for disposition of the decedent's body, and a

mechanism for referral for grief counselling. The medical examiner/coroner, police, and EMS providers should be involved in these arrangements.

17. DNAR policy should also include procedures for ensuring that organs or tissues that have been donated by the decedent can be procured appropriately.

2.6.4. Treatment that falls under Resuscitation

A DNR order refers specifically to CPR. It does not refer to any other treatment such as analgesia and thus palliative care is allowed. CPR stands for Cardio Pulmonary Resuscitation and is a combination of rescue breaths and chest compressions.²⁵² CPR or attempting resuscitation on a patient could also include additional interventions such as intubation, cardio-version and administering medication through an IV line to help with blood pressure regulation and the heart rhythm. The question arises, in a case where a DNR order is present, and the patient's heart is still beating, whether or not EMS providers should still be allowed to intubate a patient if indicated medically to save his or her life. Intubating a patient could be seen as an extremely invasive lifesaving technique as the patient would most likely go into cardiac arrest if not intubated, but intubation alone without chest compressions technically does not constitute CPR, so will this course of action be allowed or should no invasive measures that could potentially save the patient's life be initiated? According to the Brigham and Women's Hospital CPR is, "The vigorous emergency procedure to restore heart and lung function in someone whose heart or lungs have stopped working."²⁵³ This definition states that CPR is an emergency procedure to assist a patient whose heart OR lungs have stopped working. This means that intubation without compressions in a patient who is in respiratory arrest will constitute CPR and go directly against a DNR order.

²⁵² *Do not resuscitate order*, Medical encyclopaedia.
<https://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000473.htm> (assessed 18 December 2015).

²⁵³ *Understanding Do Not Resuscitate (DNR) Orders*.
<http://www.brighamandwomensfaulkner.org/about-us/patient-visitor-information/advance-care-directives/dnr-orders.aspx> (Assessed 18 December 2015).

The New York State Department of Health Bureau of Emergency Medical Services stated in a policy statement that: “Do not resuscitate (DNR) means, for the patient in cardiac or respiratory arrest, NO chest compressions, ventilation, defibrillation, endotracheal intubation, or medications.” It also stated that even with a patient that is choking, EMS providers is allowed to relieve the choking, but if the patient stopped breathing, no ventilation is allowed.²⁵⁴

This could be ethically challenging for EMS providers as it will be extremely difficult withholding any form of treatment in a patient going into respiratory arrest but with a pulse present which will ultimately lead to cardiac arrest. This will go strongly against the beneficence principle and the core values of EMS, but unfortunately, if there is a valid DNR order present EMS providers should not initiate CPR or, if CPR has already been started, it should be stopped once a valid DNR order is confirmed. It seems that EMS providers should refrain from providing treatment that could be seen as anything more than palliative care in cases where a DNR order is present.

2.6.5. Requirements of a DNR Order

All healthcare practitioners including EMS providers should be educated and informed about the requirements of a DNR order in order to know when a DNR order should be respected or not. If a document, which states that a patient has a DNR order, is presented to EMS providers, he or she should be able to identify as quick as possible whether or not the DNR order is valid or not. Resuscitation should without a doubt be initiated until a valid DNR order is produced and confirmed. The HPCSA indicated that in an acute life threatening situation where any delay will prejudice the outcome and it is not possible to obtain all information regarding the patient’s wishes, health care practitioners should start treatment that could be beneficial to the patient until more information can be obtained.²⁵⁵ Pennsylvania enacted a statute, Out-of-Hospital Non-resuscitation Act, which also stated that in a

²⁵⁴ *Frequently Asked Questions re: DNR’s*. Policy Statement. The New York State Department of Health Bureau of Emergency Medical Services 1999. <http://www.health.ny.gov/professionals/ems/policy/99-10.htm> (Accessed 11 December 2015).

²⁵⁵ n 250 Para 6.

case where there is any doubt about the validity of a DNR order, CPR should be administered.²⁵⁶In an article, *EMS, Suicide, and the Out-of-Hospital DNR*, David M. Sine made the following statement:

EMS providers are often confronted with rapid and acute changes in a patient and have only seconds to determine the patient's resuscitation status. Thus, initially starting resuscitation efforts and then suspending them only after proving to be unsuccessful may be an attractive choice for EMS first responders.²⁵⁷

It is important for EMS providers to familiarise themselves with the basic requirements of a valid DNR order. A standard DNR order form will consist of the name, surname, ID number and signature of the relevant patient; the information, signature and licence number of the attending doctor and the signature of two witnesses. It is also good practice to include the diagnosis of the patient as well as the reason for the DNR order. If a patient is not mentally competent to make such a decision, it should be mentioned in the document and the signature of a substitute, proxy or surrogate healthcare decision-maker should also be included as well as any other stakeholders in the decision making process.²⁵⁸ These are thus the most important aspects to look for when assessing if a DNR order is valid or not. Because South Africa does not have any Out-of-Hospital Do-not-Resuscitate order forms, the standard DNR order form that is used in hospitals, should be valid in an out of hospital setting. Family members should remember that the wishes of the patient has to be respected at all times and thus if there is a valid DNR order present, but the family wants EMS providers to initiate CPR, the DNR order has to be respected regardless of the families requests.

²⁵⁶ Out-Of-Hospital Do-Not-Resuscitate Orders, <http://www.portal.state.pa.us/portal/server.pt?open=514&objID=556980&mode=2> (Accessed 13 December 2015)

²⁵⁷ Sine *EMS, Suicide, and the Out-of-Hospital DNR Order*. Online Journal of Health Ethics, 2010. <http://dx.doi.org/10.18785/ojhe.0601.02>. (Accessed 13 December 2015).

²⁵⁸ *Netcare Hospitals Do Not Resuscitate Order Form; Out of Hospital Do Not Resuscitate Program*, Texas Department of Health Services. <http://www.dshs.state.tx.us/emstraumasystems/dnr.shtm>. (Accessed 26 December 2015); *ALABAMA Emergency Medical Services Do Not Attempt Resuscitation Order*. <http://adph.org/ems/assets/EMSDNAR.pdf> (Accessed 26 December 2015).

2.6.6. Life span of a DNR Order

To date there is no rule that states that a DNR order has to be updated or renewed in order for it to be valid and respected. It is however good practice to keep it up to date and to ensure that the DNR order reflects the patient's most recent wishes. A doctor should make a note about any recent discussions or changes to a DNR order in the patient's file. The New York State Department of Health Bureau of Emergency Medical Services also stated that an Out of Hospital DNR order does not expire and should be respected regardless of the date on the form.²⁵⁹ A patient is allowed to withdraw or cancel a DNR order at any time and should ensure that all relevant medical practitioners as well as family members are aware of this. Any DNR order forms should then be destroyed in order to avoid any misunderstandings. If a patient revokes a DNR order, the doctor has to decide if it should be issued on grounds of futility.²⁶⁰ With regards to in-hospital situations, hospitals will have certain policies applicable on DNR orders and these policies will also consist of reassessment and revocation of DNR orders. This means that a DNR order should be reassessed as part of the on-going evaluation of an in-patient. The Cleveland Clinic in Ohio made the following statement regarding DNR orders in their hospital:

A DNR order should be affirmed, modified, or revoked only after a discussion between the primary physician and the patient, if possible, or the surrogate(s) if appropriate, and the consent of the patient or surrogate. DNR orders should be reassessed frequently and as conditions warrant.²⁶¹

A DNR order does not have to accompany a living will to be valid. As stated above, a DNR order can be initiated if a patient has made an advance directive (e.g. a living will) OR makes an informed decision to refuse CPR.²⁶² Usually a patient with a DNR order will also have a living will which clearly states their wishes when it comes to end of life decisions. A doctor's decision to initiate a DNR order may be based on the patient's wishes in a living will, but this is not a requirement for a valid DNR order.

²⁵⁹ n 254.

²⁶⁰ n 249..

²⁶¹ *Policy on Do Not Resuscitate*, Department of Bioethics, Cleveland Clinic. <http://www.clevelandclinic.org/bioethics/policies/dnr.html> (Accessed 12 January 2016).

²⁶² n 249.

On the other hand, a living will on its own without any mention of a DNR order cannot be used to prevent CPR in the pre-hospital setting.

2.6.7. Who can Request a DNR Order?

Patients have the right to refuse any medical treatment, regardless of the consequences. Mentally competent patients are therefore allowed to refuse treatment after all the risks and benefits have been explained to them and they understand and appreciate those risks and benefits. The NHA states that health care professionals must inform patients about their right to refuse medical treatment.²⁶³ The question then comes to mind if a young healthy person will be allowed to request a DNR order? Because of patient autonomy and the right to refuse medical treatment based on Section 12(2)(b) of the Constitution,²⁶⁴ which states that everyone has the right to bodily and psychological integrity which includes security and control over their body, even if it could potentially lead to death, a healthy person will be allowed to request a DNR order. In *Castell v De Greeff*²⁶⁵ acknowledgment and acceptance of the right of the patient to refuse a life-saving medical intervention was emphasised regardless of a terminal illness.²⁶⁶ But because of the fact that a doctor has to issue a DNR order and is allowed to refuse to issue such order, a young healthy person will have difficulty in finding a doctor who will agree to issue a DNR order based solely on the patient's wishes not to receive CPR, regardless of the patient's health and cause of cardiac or respiratory arrest. According to Pennsylvania's Out-of-Hospital Non-resuscitation Act, only the following people are permitted to request a DNR order, "A person who has an end-stage medical condition who is competent and 18 years of age or older or, if under 18 years of age, has graduated from high school, has been married or is emancipated." Being terminally ill is thus a requirement (DNR has to be based on futility) and hence a healthy person will according to law not be allowed to

²⁶³ NHA, Section 6(1)(d).

²⁶⁴ The Constitution of the Republic of South Africa 1996, Section 12(2)(b).

²⁶⁵ *Castell v De Greeff*, *Supra*.

²⁶⁶ *Euthanasia and the artificial preservation of life*. South African Law Commission Report Project 86. Pretoria, November 1998. 43. http://www.justice.gov.za/salrc/reports/r_prj86_euthen_1998nov.pdf (Accessed 3 January 2015).

request such order in the State of Pennsylvania.²⁶⁷ It is a completely different story if a young healthy person decides to write a living will which states that if he or she becomes ill in the future with no prognosis, a DNR order should be included into the living will.

2.6.8. Suicide and DNR Orders

Another complicating issue is whether or not a DNR order should be respected in a case where the patient attempted suicide. D.M. Sine mentioned that only a handful of states that provide guidance on Out-of-Hospital DNR protocols, addresses the challenges of suicide attempts, and those that do, state that any suicide attempt that fall outside of a permitted physician suicide, will abolish the DNR order.²⁶⁸ Other jurisdictions, such as the State of New York emphasises that patient autonomy and the right to refuse resuscitation goes above all other medical trauma including suicide and thus it is imperative that a valid DNR order is respected, regardless of the circumstances in which it became relevant.²⁶⁹

It is extremely difficult for EMS providers to make an informed decision where a DNR order and attempted suicide are present at the same time. The legal and ethical complications are immense and a straight forward answer is almost impossible. On the one hand, you have patient autonomy which states that a patient has a fundamental right to refuse medical treatment, and on the other hand the beneficence principle comes to mind. At the end of the day, the foremost challenge that needs to be addressed is the capacity of the patient at the time of the suicidal act. Patient autonomy has always been based to some extent on an assumption of a patient's capacity to comprehend the consequences of a recommended action.

According to the Oregon Death with Dignity Act²⁷⁰, a decision from a patient with sufficient capacity, who wishes to commit suicide, should be respected within certain

²⁶⁷ n 256.

²⁶⁸ n 257.

²⁶⁹ n 254.

²⁷⁰ Death with Dignity Act 1997.

boundaries as a competent decision, and therefore autonomy cannot be set aside based solely upon the revision of a medical or legal system's opinion of the patient's capacity at the time of the suicide attempt.²⁷¹ But many suicide attempts are seen as irrational acts and thus it could be argued that someone attempting suicide does not consist of sufficient capacity at the time. A statement which recognises this is found in the following article: *Suicidal patients in the ED: ethical issues*:

Generally, we intervene with the suicidal patient based on the assumption that the person is suffering from a mental illness that impairs judgment. This assumption is usually correct, with 90% of suicides being found on post-mortem psychological review to be associated with mental illness such as depression, substance abuse, or psychosis. The physician assumes that he or she is acting beneficently in preventing harm (in this case self-harm) from coming to the patient, who is incapable of making a rational choice. Most, but not all, physicians would agree that certain mental illnesses so impair the person as to make autonomous decisions impossible.²⁷²

According to the New Mexico Administrative Code, resuscitation should be initiated if there is any doubt about the validity of a DNR order or if there is any suspicion that the patient attempted suicide. In such cases medical control should also be contacted for advice.²⁷³

There are several different opinions and views with regards to DNR orders where the patient attempted suicide and this will be an on-going debate for years to come. A policy should be created that deals specifically with DNR orders and suicides in specific jurisdictions in order to generate more transparency on this topic, as it clearly consists of numerous ethical and legal difficulties which won't easily be resolved. However, in South Africa, patient autonomy; a patient's fundamental right to bodily integrity enshrined in the Constitution; and Section 6 of the NHA makes it

²⁷¹ n 257.

²⁷² Schmidt and Zechnich *Suicidal patients in the ED: ethical issues*. Emerg Med Clin North Am. May 1999. See also Geppert. *Saving Life or Respecting Autonomy: The Ethical Dilemma of DNR Orders in Patients Who Attempt Suicide*. The Internet Journal of Law, Healthcare and Ethics. 2010. (Accessed 29 December 2015).

²⁷³ *Emergency Medical Services Advance Directives*. New Mexico Department of Health EaRD, Office of Health Emergency Management, Emergency Medical Systems Bureau. ed. 7. Vol 27. Santa Fe, New Mexico 2006.

quite clear that a patient has the right to refuse any lifesaving treatment, and because of the fact that suicide is not a crime, it seems that in South Africa a DNR order should always be respected regardless of the circumstances.

It is clear that DNR orders are complex and could be quite challenging in the pre-hospital setting. South Africa does not nearly have enough guidelines with regards to giving effect to a DNR order, which complicates things for health care professionals, especially practitioners in the pre-hospital setting. A standard Out-of-Hospital DNR document could potentially exclude a number of medico-legal issues experienced in the emergency setting and educating EMS providers sufficiently on how to work with these situations could assist them when they are confronted with DNR orders in the future.

According to the Ethics Institute of South Africa (EthicsSA), living wills should be unambiguously recognised and issues surrounding it, such as format and minimum requirements; whether it may be overridden in certain circumstances; and whether someone acting on it is immune from criminal and civil liability, should be addressed accordingly. This should count for all forms of advance directives as well as DNR orders, especially DNR orders in the pre-hospital setting.²⁷⁴

2.7. Restraining of Patients

In the pre-hospital environment, EMS providers are regularly confronted with aggressive patients or patients who do not consist of sufficient mental capacity to make informed decisions about their health care and are thus a potential threat to themselves. Unfortunately in these types of situations EMS providers often have to go to extreme measures in order to assist and treat those patients.

²⁷⁴ Landman *End of life decisions, ethics and the law: A case for statutory legal clarity and reform in South Africa* Ethics Institute of South Africa. 18 May 2012.

2.7.1. The Mental Health Care Act

In South Africa the Mental Health Care Act (MHCA) does not make provision for EMS providers to restrain and/or sedate patients in the pre-hospital environment. Ironically enough, it is more often than not the EMS providers who are called upon to assist in situations where patients act abnormal or violently because of mental impairment caused by illness or substance abuse. Restraining of patients, either by chemical or physical means, will typically be necessary when patients present a real threat to themselves or others because of a mental illness or because of the use of recreational drugs. In some cases, it could be necessary to restrain a patient that is in need of medical treatment but refuses treatment and transportation while not consisting of sufficient mental capacity at the time. These patients might not be aggressive, but often it could take more than verbal convincing to be able to treat and transport these patients.

Section 40 of the MHCA makes provision for intervention by the South African Police Service (SAPS). The Act states that, if a member of the SAPS have reason to believe, either by personal observation or because of information obtained by a mental health care professional, that a person is likely to inflict harm to him or herself or others because of a mental illness or disability, the SAPS member should apprehend that person and cause that person to be taken to an appropriate facility for assessment and handed over to the head of the health establishment. The Act also states that a member of the SAPS may make use of restraining measures as far as necessary in order to apprehend the person.²⁷⁵

2.7.2. Restraining Patients Outside of Hospital

It is extremely challenging and dangerous for EMS providers to restrain individuals who comes across aggressive and violent. C.H. Schultz, MD, made the following accurate statement in an article about the restraining of patients in the pre-hospital

²⁷⁵ Mental Health Care Act 17 of 2002, Section 40(1)(a),(b) and 40(8).

environment: “The dilemma confronting paramedics is they can’t provide medical care until they can restrain the individual and they can’t restrain the individual until they provide sedation.”²⁷⁶ As mentioned earlier in this chapter, when a patient does not want to give his or her consent to be treated and/or transported to hospital, it could be necessary to involve the police, which is not always a practical solution as the police are sometimes very reluctant to assist in these situations. If that is the case, EMS providers will have to restrain the patient on their own although this is technically not legal. Out of practical experience, restraining a patient will always be the last resort and it will only be used in cases where the patient poses a real threat to him or herself or to others including EMS providers. Although neither the MHCA, nor any other legislation makes provision for this type of intervention, it could be argued that by common law restraining of patients in these circumstances will be allowed because EMS providers will be acting in self-defense and/or in the best interests of the patient. It will understandably be sensible to first try to obtain assistance from the police before going to extreme measures to restrain the patient, as police presence might convince the patient to cooperate voluntarily.

According to the MPS, there are specific situations when it is possible to restrain those with presumed capacity – In an emergency situation; where the patient is a threat to themselves or others; and where the patient may damage property. *The Mental Capacity Act* of the United Kingdom²⁷⁷ deals with acts of care and treatment and the use of restraints. The Act states that:

Restraint is only permitted if the person using it ‘reasonably believes that it is necessary to do the act in order to prevent harm’ to the incapacitated person. If restraint is used it must be proportionate to the likelihood and seriousness of the

²⁷⁶ *Ketamine for Pre-hospital Control of Agitated Delirious Patients: Promising but Not yet Ready for Prime Time*. West J Emerg Med. 2014 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4251213/> (Accessed 2 January 2016).

²⁷⁷ *The Mental Capacity Act 2005 (c 9)*. www.legislation.gov.uk/ukpga/2005/9/section/5 and www.legislation.gov.uk/ukpga/2005/9/section/6 (Accessed 2 January 2016).

harm. Remember that restraint does not have to involve touching a patient, but may involve locking the door or prescribing medication to sedate them.²⁷⁸

In a case where restraining is necessary it is very important to document every detail. This includes the restraints used; assessment of capacity; as well as benefits of restraining in comparison with the risks.²⁷⁹ This is imperative in order to protect the relevant practitioner against possible future investigation.

According to the MHCA, certain regulations apply when restraining a patient. Only those relevant to the pre-hospital setting will be mentioned:

- 1) Mechanical means of restraint may not be used during transfer of a mental health care user or within a health care establishment unless pharmacological or other means of calming, physical means of restraint or seclusion of the user are inadequate to ensure that the user does not harm him- or herself or others.
- 2) Where mechanical means of restraint are required in order to administer pharmacological treatment, such means should be applied for as short a period, depending on the condition of the mental health care user concerned, as is necessary to effect the treatment.
- 3) When the mental health care user is under restraint, he or she must be subjected to observation at least every 30 minutes and such observations should be recorded.²⁸⁰

These regulations imply that restraints should not be used for longer than necessary and as soon as it has had the desired effect to a point where control is regained, further imposition is illegal.²⁸¹

²⁷⁸ *MPS dilemma – Is it ok to physically restrain a patient?* Medical Protection Society, <http://www.medicalprotection.org/uk/casebook-and-resources/new-doctor/vol-6-no-2-2013/mps-dilemma-is-it-ok-to-physically-restrain-a-patient> (Accessed 2 January 2016)

²⁷⁹ *Ibid.*

²⁸⁰ Moosa and Jeenah *The use of restraints in psychiatric patients* SAJP 2009. See also Mental Health Care Act 17 of 2002: **Regulations**. Pretoria: Department of Health. 2004. <http://www.info.gov.za/gazette/acts/2002>. (Accessed 10 January 2016).

²⁸¹ n 280.

2.7.3. Guidelines for Restraining Patients

In the USA, the Regions Hospital EMS created guidelines for the use of restraints in the pre-hospital setting. These are only guidelines and should be read in conjunction with any laws, regulations and policies that are applicable to the relevant jurisdiction.

INDICATIONS:

1. Behaviour or threats that create or imply a danger to the patient or others.
2. Safe and controlled access for medical procedures.
3. Change in behaviour that results from improvement or deterioration of patient condition, i.e. hypoglycaemia, overdose, intubation.
4. Involuntary evaluation or treatment of incompetent combative patients.

PRECAUTIONS:

1. Be aware of items at the scene or medical equipment that may become a weapon.
2. Assure that the scene is safe before approaching the patient.
3. Patients that are actively seizing should never be restrained.
4. The patient should be restrained in the prone position only as a last resort and only with continuous monitoring. This position may interfere with the patient's ability to breathe.
5. Restraining a patient's hands and feet together behind the patient (hog-tying) is not allowed. The only exception is a prisoner or suspect in the custody of law enforcement or prison authorities.

GENERAL RESTRAINT PROCEDURES:

1. Make every attempt not to aggravate or worsen pre-existing injuries or medical conditions.
2. Attempt first to control the patient with verbal counselling.
3. The least restrictive means of control should be employed.
4. Only "reasonable force" may be used when applying physical control. This is generally defined as the use of force equal to, or minimally greater than, the amount of force being exerted by the resisting patient.

5. Restraints should not interfere with the assessment or treatment of the patient's ABCs.
6. The decision to restrain a patient should usually be made prior to transport.
7. Do not remove restraints once applied unless the patient seizes. If circulation becomes compromised, the benefit of removing the restraints must be weighed against crew safety.
8. EMS does not apply handcuffs or hard plastic ties (flex cuffs), but if already in place and circulation is adequate, may be left on. Handcuffs must be double locked to prevent inadvertent tightening, and should allow one little finger to fit between the handcuff and the wrist. Assure that a key is available during transport.
9. Restraints should be individualized and afford as much dignity to the patient as the situation allows. Attempt to accommodate patient comfort or special needs whenever possible.
10. Ensure that enough help is available to ensure patient and provider safety during the restraint process. Optimally, five people should be available to apply full body restraint (one for each limb and one for restraint application). Communicate the restraint plan to all help.
11. Assure that the patient's clothing and personal belongings have been searched for weapons prior to transport.
12. An emergency transport hold must be obtained and completed whenever a patient is transported against their will for the above mentioned reasons.

ADVANCED LIFE SUPPORT CARE:

1. For combative behaviour that is compromising the ability to provide patient care, consult with medical control for sedation medication orders.

PEDIATRIC CONSIDERATIONS:

1. Always attempt to involve parents when restraining children.

PREGNANCY CONSIDERATIONS:

1. Pregnant women should be restrained in a semi-reclining or left lateral recumbent position.

DOCUMENTATION REQUIREMENTS:

1. An emergency existed.
2. The need for treatment was explained to the patient (regardless of competence).
3. The patient refused treatment or was unable to consent to treatment.
4. Evidence of the patient's incompetence to refuse treatment.
5. Failures of less restrictive methods of control (such as verbal counsel).
6. The restraints were used for the safety of the patient or others.
7. The reasons for restraint were explained to the patient (regardless of competence).
8. The type/method of restraint used and which limbs were restrained.
9. Injuries that occur during the restraint procedure.
10. Which agency placed the restraints.
11. Continuously assess CMS (distal to the restraints) and the patient's ability to breathe.²⁸²

The restraining of patients can be a substantial infringement on an individual's rights, especially the right to autonomy and self-determination. Because of this, it should always be seen as the exception and handled with the utmost caution. The MHCA should, in the future, make provision for the inclusion of EMS providers when referring to apprehending of persons in involuntary cases and also provide regulations specifically with reference to the pre-hospital environment. Australia is a good example where legislation provides for paramedics or ambulance personnel to restrain patients where necessary.

The Mental Health Act 2014 (No. 26 Of 2014) - Sec 350 of Victoria states the following:

Bodily restraint and sedation may be used when taking a person

- (1) Despite anything to the contrary in Part 6, if a person is required under this Act to be taken to or from a designated mental health service or any other place—
 - (a) an authorised person may use bodily restraint on the person if—

²⁸² *Regions Hospital Emergency Medical Services, Year 2000 EMS Guidelines.* http://wearcam.org/decon/full_body_restraint.htm. (Accessed 31 December 2015).

- (i) all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable; and
 - (ii) the bodily restraint to be used is necessary to prevent serious and imminent harm to the person or to another person; and
- (b) a registered medical practitioner may administer sedation to the person or direct a registered nurse or **ambulance paramedic** to administer sedation to the person if—
- (i) all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable; and
 - (ii) the sedation to be administered is necessary to prevent serious and imminent harm to the person or to another person.
- (2) Subsection (1)(b) does not limit the power of a registered nurse or **ambulance paramedic** to administer sedation within the ordinary scope of his or her practice.²⁸³

This might not happen in the near future in South Africa and thus, until the legislature makes sufficient provision for restraining of patients out of hospital, a standard policy or set of guidelines produced by the Professional Board for Emergency Care could assist greatly in these cases and shed some light on the ethical and legal difficulties that comes to mind when restraining of patients is necessary.

The examples of guidelines given above are quite comprehensive and the researcher believes that those guidelines could work just as well in South African Law as it does in the USA. In the USA, people are very quick to sue medical professionals, including EMS providers, and because of this their guidelines with regards to restraining of patients; refusal of treatment and DNR orders etc. could work potentially well in South Africa as medical malpractice lawsuits are also on a rise in this country.

²⁸³ *The Mental Health Act 2014 (No. 26 Of 2014) - Sec 350*. Victorian Numbered Acts. http://www.austlii.edu.au/au/legis/vic/num_act/mha201426o2014174/s350.html (Accessed 29 May 2016).

2.8. Patient Abandonment

2.8.1. Definition of Patient Abandonment

A patient is abandoned when a doctor ceases treatment before the patient has recovered or has terminated his or her contract with the doctor, and the doctor does not refer the patient to another practitioner or institution that can continue such treatment.²⁸⁴

This definition is specifically applicable on doctors in a hospital setting, although it can be interpreted to include EMS providers in the pre-hospital setting. D. McQuoid-Mason stated in an article in *The Bulletin* of the HPCSA, that paramedics creates a patient-practitioner relationship when they attend to a patient and that leaving a patient unattended at the back of an ambulance or on the scene of an accident, could amount to patient abandonment depending on the circumstances.²⁸⁵ A definition of patient abandonment specifically applicable on the EMS could be as follows:

A patient is abandoned when an EMS provider leaves a patient on scene or in the back of the ambulance after a relationship of care has been established or, if an EMS provider hands over a patient to a practitioner with inadequate training to care for that specific patient or, fails to hand over the patient to any practitioner at a health care facility.

According to the same article as mentioned above, a patient will be deemed abandoned when: A patient is refused emergency medical treatment due to an inability to pay; when a health care practitioner leaves a patient in the care of another practitioner whom is not able to treat the patient adequately; and when paramedics leaves a patient unattended at the back of an ambulance while they sit in front. These are just a few examples which could be applicable in the pre-hospital environment and EMS providers should familiarise themselves with the term patient

²⁸⁴ McQuoid-Mason & Dada (2011) 1.

²⁸⁵ Cele *A Crying Shame*, *The Bulletin* 2013, HPCSA. Also see HPCSA 2008 Booklet 1, *General Ethical Guidelines for the Healthcare Professions*. Para 5.1.1; 5.2.5 and 5.7.1. <http://www.hpcsa.co.za> (Accessed 3 January 2016).

abandonment in order to assist them in making responsible choices and to limit liability. In order for a plaintiff to prove patient abandonment, the plaintiff will have to prove that the plaintiff was injured and thus in need of medical treatment and that the EMS providers had entered into some sort of relationship to provide that care, and then either stopped providing care or failed to transfer care to another competent practitioner, or transferred care to someone with lesser training not able to render the necessary care.²⁸⁶

2.8.2. How to Avoid Abandoning a Patient

When an EMS provider transfers care of a patient to a lesser trained individual, this will not necessarily constitute patient abandonment. If the ALS on scene did not start any ALS treatment and such treatment is not necessary, it will be more than acceptable to leave treatment in the hands of either the ILS or BLS provider, depending on the level of care needed. This will not constitute patient abandonment, but leaving a patient with the BLS provider after ALS interventions have been given or are necessary, will constitute patient abandonment and negligence.

EMS providers should remember that patient abandonment could possibly occur if they fail to hand over the patient at the emergency department. Handing over of a patient at a hospital consists of handing over a document with all necessary details to either a nurse or a doctor who will presume care of the patient. It is good practice to give a verbal handover along with the document and to ask for a signature on the document as proof of handing the patient over to another health care professional.

It goes without saying that EMS providers are never required to risk their own safety, and thus when any scene is unsafe or even just seems unsafe, it will not constitute

²⁸⁶ Maggiore *Patient Abandonment: What It Is -- And Isn't, Ems and the Law* JEMS Editorial Board member 2007. <http://www.jems.com/articles/2007/09/patient-abandonment-what-it-an-0.html>. (Accessed 6 January 2016).

patient abandonment if the EMS providers wait in a safe location for the police to assist them before entering a scene and assisting patients. If EMS providers respond to any call such as a stabbing, gunshot or domestic violence and they arrive at the scene before the police, they should refrain from entering the scene before the police has made sure that the scene is safe for them to enter. In a case where EMS providers are already on a scene and the scene becomes unsafe for whatever reason, they should leave the scene without the patient if necessary, as soon as possible and move to a safe location until the police arrives.

In 2004, two paramedics of the City of Johannesburg were found guilty of negligence and removed from the roll after they left a homeless man who had collapsed and fell into a gutter, next to the road. The man was found dead 16 hours later exactly where the paramedics left him.²⁸⁷ Because of the fact that the patient was in need of medical treatment and the paramedics responded to the scene and assisted the patient from where he had collapsed and then left him there afterwards, it could be argued that this is a good example of patient abandonment which ultimately leads to negligence. In cases like these it is very important for EMS providers to ensure that the patient signs a RHT document if he or she stated to the paramedics that he or she did not want any assistance in order to prove that the patient was not simply just abandoned for other reasons.

D. McQuoid-Mason wrote an article about ‘over-servicing’, ‘underservicing’ and ‘abandonment’ and stated that the HPCSA rules are silent on abandonment of patients. He also stated that the South African courts do not generally mention abandonment but they rather treat it as an omission and thus the general principles of liability and professional negligence apply. In cases like these, the courts may also rely on the HPCSA’s ethical rules, the ethical guidelines and the policy document on

²⁸⁷ Kgosana *'Too-dirty' hobo: medics guilty of negligence* 2004. <http://www.iol.co.za/news/south-africa/too-dirty-hobo-medics-guilty-of-negligence-1.223217> (Accessed 4 October 2015); Eliseev *Struck off roll for leaving 'dirty patient'* 2006. <http://www.iol.co.za/news/south-africa/struck-off-roll-for-leaving-dirty-patient-1.265283?ot=inmsa.ArticlePrintPageLayout.ot> (Accessed 4 October 2015).

undesirable business practices. The USA courts have however found doctors liable for patient abandonment in certain cases.²⁸⁸

The Patients' Rights Charter makes it clear that no one shall be abandoned by any health care professional or health facility after they have taken responsibility for a patient's health.²⁸⁹ Because patient abandonment falls under the ambit of medical negligence, health care professionals, including EMS providers should be cautious before simply handing over a patient to another health care professional or leaving a patient after any form of responsibility to care for that patient has been established, as the consequences could be disastrous.

2.9. Declaration of Death

2.9.1. Requirements of a D.O.D Document

In the EMS, a practitioner with a qualification of ILS or higher, is allowed to declare a person dead on scene if certain circumstances are present.²⁹⁰ Declaring a person dead includes completing a document that states the identification of the patient; how and where the patient was found; stating that all necessary checks to declare a person dead was done; the information and signature of a family member, undertaker or SAPS member the document was handed over to; and lastly the information of the person that completed the document.²⁹¹ A declaration of death document or a D.O.D must be completed in the case of a natural death as well as an unnatural death. EMS providers will base their decision whether the death was natural or unnatural on the specific circumstances present. This could be anything

²⁸⁸ McQuoid Mason 'Over-servicing', 'underservicing', and 'abandonment': What is the law. SAMJ, March 2015 See also Strauss (1991) 3 and *Hill v Midlantic Health Care Group* 33 A.2d 314 (D.C. 2007).

²⁸⁹ Patients' Rights Charter.

²⁹⁰ Intermediate life support practitioner guidelines, Professional Board for Emergency Care, HPCSA, form 289. 2006. 21.

²⁹¹ Declaration of Death document. Netcare911.

from age and medical history to where and how a person was found. Sometimes EMS providers will rule a death as unnatural and request the police to come out and investigate, based on something that just did not seem right. The police will then come to the scene and along with the EMS providers decide whether an investigation should be opened or not. Every D.O.D document has to be handed over to either the police with an unnatural death or the undertakers in the case of a natural death. In the event of a MVA; PVA; suicide; homicide; or any other accident, the death has to be ruled as unnatural and the D.O.D has to be handed over to the police on scene.

According to the HPCSA, ILS providers may declare death, and in such cases there is no need for further declaration by a medical practitioner before the body can be removed from the scene. An ILS or ALS provider may declare a person dead in the following circumstances,

A. The person is obviously dead due to / evidenced by:

1. Decapitation or mortal disfigurement
2. Rigor mortis
3. Putrefaction
4. Post mortem lividity

OR

B.

1. There is no evidence of cardiac electrical activity on electrocardiogram in all 3 leads for 30 seconds or more (if ECG available); **OR**
2. There are no palpable central pulses; **and**
3. There are no audible heart sounds; **and**
4. Bilateral fixed dilated pupils are present; **and**
5. There has been no spontaneous breathing for the past 5 minutes; **and**
6. Absent oculo-cephalic reflex; **and**
7. Absent gag and corneal reflexes.²⁹²

²⁹² n 290.

It has to be noted that a D.O.D document is not a death certificate or a Death Notification Form (DNF). The DNF allows the Department of Home Affairs to issue a death certificate. The DNF provides important information about the deceased and about the circumstances and cause of death.²⁹³ According to Section 15 of the Births and Death Registration Act,²⁹⁴ only a medical practitioner is allowed to prescribe a certificate stating the cause of death. If there is any doubt as to whether it is a natural death or not, a medical practitioner should not issue such certificate and inform the police about the doubt. For purposes of this Act, medical practitioner means someone registered as such under the HPCSA, this includes a community medical officer. An intern is also allowed to complete a DNF because of the fact that interns are allowed to perform any function or issue any certificate that may be or is required to be performed by a medical practitioner.²⁹⁵

2.9.2. Purpose of a D.O.D Document

It seems that the declaration of death document has been created in order for a corpse to be removed legally from the scene after the person has been declared dead by someone with a medical qualification, in cases where a medical practitioner is not able to come to the scene and declare the person dead by means of a DNF. Either the undertakers or the police are allowed to remove a corpse from a scene after EMS providers has declared that person dead. From there, a medical practitioner will still have to complete a DNF for the deceased in order for Home Affairs to issue a death certificate. In the case of an unnatural death, the form has to be completed by the forensic pathologists and the form will also have to be send to the Magistrate.²⁹⁶ The Births and Deaths Registration Act does not mention a D.O.D document used by EMS providers and thus it seems that at this stage only the

²⁹³ Pieterse *et al* *Cause of Death Certification. A Guide for completing the Death Notification Form (DNF) BI-1663*. April 2009.

²⁹⁴ Births and Deaths Registration Act 51 of 1992.

http://www.saflii.org/za/legis/consol_act/badra1992301.pdf (Accessed 27 January 2016).

²⁹⁵ n 293.

²⁹⁶ *Ibid.*

HPCSA makes provision for the use of such documents and that the use of such documents are solely for the purpose of convenience and evidence in litigation.

S.A. Strauss discussed dead on arrival certificates (DOA), and mentioned that in his opinion the law does not regulate DOA statements *per se* and that DOA certificates are not certificates as required by the Births, Marriages and Deaths Registration Act. He states that although it is preferable that a medical doctor should make the DOA certificate, it can be done by any medical professional with adequate training in the diagnosis of death when a doctor is not available. It seems that the DOD documents used by EMS providers are the same as the DOA certificates discussed by Strauss.²⁹⁷

2.10. National Health Insurance (NHI)

2.10.1. What does the NHI entail?

The intention of the NHI is to address the current issues of the public and private health care system and to address all inequalities. The main purpose of the NHI will be to ensure that everyone has access to efficient and quality health care services. In December 2015 the White Paper on the NHI was released. The White Paper outlines South Africa's path to universal health coverage over the next 14 years.²⁹⁸

The first five year period will be focused on improving the public health care system overall as well as the strengthening of service delivery. This phase will be extremely important as it will be near impossible to implement a new national health care system if the basic structures in the public health sector hasn't been resolved and improved. The second five year phase will be the implementation of a NHI card to all South Africans and permanent residents. The final four year period will ensure that the NHI fund is fully functional and effective. According to the White Paper, the NHI

²⁹⁷ Strauss (1991) 329.

²⁹⁸ *White paper: National Health Insurance for South Africa*. Health-e News. December 2015. <https://www.health-e.org.za/2015/12/14/white-paper-national-health-insurance-for-south-africa/> (Accessed 4 February 2016).

financing requirements are still unclear and to a certain extent depend on the improvements of the public health sector and medical aid regulatory reforms.²⁹⁹

A. Hassim made the following statement when addressing the NHI and the legal and civil considerations:

The extent to which the National Health Insurance (NHI) system will strengthen equality in health, rapidly revitalize health services and ensure sufficient funding for health is still unknown. Given the strong legal architecture in the country, it is important that existing laws and, in particular, the guidance provided by the Constitution, is harnessed towards full and effective implementation of a NHI policy that advances access to quality health services.³⁰⁰

2.10.2. The effect of the NHI on the EMS of South Africa

The NHI will without a doubt affect the EMS of South Africa. Section 6.9 of the White Paper addresses the issues of the EMS. According to this section, the NHI will contract with accredited providers of the public and private EMS providers and a uniform level of quality for EMS will be provided across the country according to nationally determined standards and norms. All EMS vehicles and uniforms will be of a standard colour regardless of whether they are publicly or privately operated. There will also be one universal emergency number to improve effective response to the population as a whole.³⁰¹

The NHI will bring tremendous change to the health care system and the EMS will be no exception. It remains to be seen exactly how the EMS system will operate when the NHI is implemented and if a universal EMS system will be effective in rendering emergency services to all South African citizens.

²⁹⁹ *Ibid.*

³⁰⁰ Hassim *Profile, National Health Insurance: legal and civil society considerations*. SECTION 27 and School of Law, University of the Witwatersrand, Johannesburg. SAHR 2010. 205.

³⁰¹ National Health Insurance in South Africa, White paper, December 2015. www.gov.za/sites/files (Accessed 28 January 2016).

3. Conclusion

It is quite clear that the pre-hospital environment consists of numerous grey areas and that EMS providers have to deal with situations that desperately need guidelines or some sort of regulated framework in order to provide more legal clarity.

In the modern South Africa patients' rights have become very dominant and the rights of patients should be the highest consideration when performing any medical service. A patient's rights are regularly set aside in the EMS due to regulations not being met or because of the fact that most of the private EMS companies are struggling financially. The new EMS regulations, once implemented, will have a tremendous effect on protecting patients' rights in the future.

Negligence plays a big role in medical law and professional medical negligence is part of the vocabulary of professionals in all the different branches of the medical profession including the EMS. Anyone in the medical profession, including EMS providers have to exercise the degree of skill and care expected of a reasonable competent professional in their specific branch of the profession, and they should refrain from acting outside their scope of practice in order to avoid any allegations of medical negligence. Because of the fact that the pre-hospital environment is not as predictable and regulated as in hospital situations and if you consider the circumstances that EMS providers work in, the question arises if a bigger margin of error should be considered when assessing negligence in the pre-hospital environment.

In an EMS setting, consent and informed consent is just as important as in any other medical profession. Obtaining consent from patients could seem straight forward, but unfortunately there are always patients who complicate certain situations and thus it is vital for EMS providers to understand the rules of consent. Consent is one of the most important legal grounds of justification for medical interventions and given the difficulties experienced by EMS providers in their environment, they should be formally trained in how to assess a patient's level of competence in order to make informed decisions regarding patient treatment and transportation.

Patient confidentiality on the other hand is a duty imposed on health care professionals to respect a relationship of trust between themselves and the patients, and because of the fact that privacy is enshrined in the Constitution, it is important for EMS providers to know when they are allowed to disclose certain information and when they will be held accountable if they do so. The HPCSA as well as the NHA provides helpful guidelines and makes it quite clear when and how patient information may be disclosed regardless of their right to privacy. EMS providers should ensure that all necessary information regarding the patient's health is provided to the health care professionals resuming care and that those health care professionals are aware of the fact that all information provided should be treated with the utmost confidentiality.

Legal documentation plays such an important role in legal disputes and is an integral part of patient care. All patient records should contain as much information as possible and should be stored in a safe place. All medical professionals should familiarise themselves with the requirements of different legal documentation and should ensure that they will feel confident using that documentation to defend themselves in a legal battle. In the case of RHT documentation, a set of guidelines will help tremendously in order to ensure that the EMS providers covered all bases before accepting or rejecting a patient's refusal. A type of checklist provided by the Professional Board for Emergency Care will be a very helpful tool in difficult cases and provide more legal clarity.

DNR orders are probably one of the greyest areas in medical law and when applying them to the EMS it gets even more complicated. In South Africa, no mention is made of any out of hospital DNR orders and thus the general rules of DNR orders used in hospitals has to be applied in the pre-hospital environment. Because patient autonomy is so important, EMS providers should be educated on DNR orders in order to know when they can be respected or not. In South Africa, a general DNR order form can be accepted in an out of hospital setting and thus EMS providers should familiarise themselves with the requirements of such document and has to understand that a legal DNR order document has to be present in order for EMS providers to withhold CPR. Patient autonomy should always be respected even though medical professionals sometimes find it hard to go against the principle of

beneficence. The HPCSA should construct a DNR policy and most importantly, an out of hospital DNR policy which will ensure maximum consistency and compliance and eliminate any confusion on this topic.

In the pre-hospital environment, EMS providers are regularly confronted with aggressive patients or patients who do not consist of sufficient mental capacity to make informed decisions regarding their health. Sometimes in these cases, EMS providers have to go to extreme measures to restrain those patients although the MHCA does not make provision for them to do so. Because these situations are so challenging, the MHCA should include EMS providers into the act and allow them to legally restrain patients within certain limitations. The USA created guidelines which are very helpful in situations where restraining is necessary. It is important for EMS providers to know and understand how and when it is justifiable to restrain patients in order to avoid any liability.

Although it is important that EMS providers are protected legally in order for them to do their work to the best of their abilities without constantly worrying about law suites, patients' rights are very important in the modern South Africa and thus EMS providers should ensure that they know when they are abandoning a patient according to law. This will constitute an omission and a practitioner can easily be found guilty of medical negligence in these cases. It is vital to understand that as soon as any form of a relationship of care has been established, EMS providers should ensure that they do not leave the patient unattended or fail to hand over the patient to another medical professional who can take over care of the patient as the consequences could be disastrous.

In South Africa, only the HPCSA regulates declaration of death documents. No law mentions these documents and it seems that it is only used because it would be impossible for a medical doctor to come to each and every scene to declare a person dead in order for the body to be removed from the scene. This document is not a death certificate of any sort and thus a medical doctor will still have to certify a person dead and mention the cause of death before the person's death can be registered at the Department of Home Affairs.

In the future, the NHI will definitely have an effect on the EMS of South Africa. Although the White Paper does not explain exactly what the changes will be, it is clear that South Africa's EMS will become a uniform system and it remains to be seen how the system will be operated and if it will work effectively.

This chapter serves as a good illustration of the urgent need for more guidelines and policies with regards to different aspects of medical law when it is applied to the EMS. A very good start will be for the HPCSA to provide guidelines on all issues that could potentially lead to liability, which will assist EMS providers when they are confronted with difficult medico-legal issues in the pre-hospital setting.

Chapter 4

Grounds of Justification and Comparative Law

1. Overview

This chapter discusses the grounds of justification for medical interventions and how it is applicable on EMS providers. It also analyses how the law of South Africa protects EMS providers and if the grounds of justification can also be applied to the pre-hospital environment directly. Lastly, the EMS of the USA and Australia are assessed from a legal point of view and recommendations are made as to whether or not South Africa can acquire anything from the USA and Australia's EMS systems with regards to the law. The reasons for using the USA and Australia for the comparative section in this dissertation are also discussed.

2. Grounds of Justification for Medical Interventions

In medical law, there are numerous grounds of justification for medical interventions. When a medical intervention is performed in the absence of a ground of justification, it is *prima facie* unlawful or wrongful as it creates a violation of the patient's rights enshrined in the Constitution.³⁰² The grounds of justification are as follows: Consent; emergencies with reference to unauthorised administration, necessity, and deviations or extensions; Statutory Authority; court orders; *Boni Mores*; contributory negligence; prescription; and lastly error of professional judgment and medical misadventure. It is important to take note that this is not a closed list and that not all of the justifications mentioned are discussed, only those most relevant to the pre-hospital setting are analysed. It has to be mentioned that consent, which is probably

³⁰² Carstens and Pearmain (2007) 871.

the most important ground of justification, has already been discussed in Chapter Three and will thus not form part of this section. The following justifications are therefore discussed: unauthorised administration; necessity (including therapeutic necessity and therapeutic privilege); Statutory Authority; *Boni Mores*; and error of professional judgment and medical misadventure.

2.1 Unauthorised Administration

This defense, also known as *negotiorum gestio* will, apart from consent, without a doubt be the most useful ground of justification in the pre-hospital setting. Where a patient is unconscious or *non compis mentis*, it is impossible to obtain consent before any medical intervention can be performed in order to save the patient's life or preserve his or her health. In those cases, the defense of *negotiorum gestio* will render the medical treatment lawful.³⁰³

The requirements for this defense are as follows:³⁰⁴

1. There must be a situation of emergency.
2. The patient must be incapable of giving consent.
3. The intervention must not be expressly against the patient's will.
4. The intervention must be in the patient's best interests.

According to D McQuoid-Mason, *negotiorum gestio* is: "The voluntary management by one person of the affairs of another without the consent of the other person." This defense is governed by the common law and in the field of health care, emergency medical treatment is the best example of a situation where *negotiorum gestio* is relevant.³⁰⁵ According to Van Oosten, the essence of unauthorised administration

³⁰³ *Id* 907. Van Oosten *International Encyclopaedia* para [133]; Strauss *Doctor Patient and the Law* 92; Strauss *International Encyclopaedia* para [139]; Coetzee *Medical Therapeutic Privilege* (LLM dissertation, UNISA, 2001) 79, 82; Steyn *The Law of Medical Malpractice in Clinical Psychiatry* (LLM Dissertation, UNISA) 88, 90; *Stoffberg v Elliot*.

³⁰⁴ *Ibid*, See also Strauss *Doctor, Patient and the Law* 92; Strauss and Strydom 238; Claassen and Verschoor 76; Labuschagne "Negotiorum Gestio (Saakwaarneming) as Verweer in die Straf-en Deliktereg" 1994 TSAR 811.

³⁰⁵ McQuoid-Mason (2007) 294.

lies in an emergency situation and the impossibility of obtaining consent.³⁰⁶ This privilege only applies when it would be unreasonable to postpone the medical treatment until consent can be obtained, and not just inconvenient to postpone the treatment.³⁰⁷ Any expenses caused by the emergency medical treatment provided can be recovered if such treatment was not against the express wishes of the patient regardless of the treatment being successful or not.³⁰⁸

In the pre-hospital environment, the defense of unauthorised administration becomes very valuable in situations where patients are injured or ill to an extent where it is impossible for them to give their consent to receive lifesaving treatment, whether it is because of unconsciousness or because the patient is in such a state of shock that he or she is not thinking clearly. It has to be mentioned that relatives of the injured patient will not be entitled to 'veto' any necessary medical treatment, except in the case of a minor or a mentally ill person where the relative is lawfully entitled to give or refuse consent to medical treatment, provided the prohibition does not go against the best interests of the patient.³⁰⁹

In the American case of *Yackovch v Yocom*³¹⁰, the court made the following statement:³¹¹

"If a surgeon is confronted with an emergency which endangers the life and health of the patient, it is his duty to do what the occasion demands within the usual and customary practice among physicians and surgeons...without the consent of the patient."

³⁰⁶ Steyn. LLM Dissertation, 90. See also Van Oosten "Some Reflections on Emergencies as Justification for Medical Interventions" (1999) 682.

³⁰⁷ Bennett *et al. Law and Medicine*, 1988. 125.

³⁰⁸ McQuoid Mason & Dada (2011) 294.

³⁰⁹ Strauss (1991) 95. See also Neethling, Potgieter & Visser *Law of Delict* (1990) 195.

³¹⁰ *Jackovach v Yocom* 212 Iowa 914 (1931).

³¹¹ Strauss (1991) 93.

2.2 Necessity

The defense of necessity will apply where someone acts in defense of his or her or a third party's legally recognized interest, which is threatened with immediate harm. These interests could be the right to life, bodily integrity or property.³¹² This defense differs from *negotiorum gestio* in that the defense of necessity does not require that the conduct be performed in the patient's best interests, and extensive considerations of the society's best interests are relevant.³¹³

The requirements for this defense are as follows:³¹⁴

1. There has to be some sort of emergency situation;
2. This defense does not require that the patient was unable to consent, this defense will therefore be relevant where the patient was capable of consenting or where the intervention was against his or her will;
3. The medical intervention is to be performed in society's best interest.

It must be noted that the act of necessity must not be out of proportion to the interests infringed by the wrongdoer's act. In essence, the defense of necessity applies the test of how the reasonable person would have acted in the same circumstances. Health care practitioners may be able to rely on this defense if during such emergencies; they commit an act of assault because they did not obtain consent or they acted directly against the patient's wishes.³¹⁵ The NHA also states that a patient may be treated without consent in a life threatening situation.³¹⁶

Where the defence of unauthorized administration is not available because the patient is capable of consent, but refuses to do so, or the intervention is against the will of the patient or the intervention is not in the patient's best interests, medical intervention can none the less occur on grounds that it is performed in society's best interests. Therefore, for example, the vaccination against infectious disease of

³¹² McQuoid Mason & Dada (2011) 291.

³¹³ Dutton (2015) 57.

³¹⁴ Carstens and Pearmain (2007) 909. See also Steyn LLM dissertation 91; Strauss (1991) 31, 91-92.

³¹⁵ McQuoid Mason & Dada (2011) 292.

³¹⁶ NHA, Section 7(1)(e).

conscious, sane, sober and healthy people against their express will may be justified on these grounds.³¹⁷

A medical intervention against a patient's express wish for the purpose of protecting the patient's health or life will be at the expense of patient autonomy and can thus not be justified by necessity.³¹⁸ When it comes to necessity, it has to be mentioned that this defence can also be raised where the best interests of the society as a whole is not the aim of the defence. Public necessity will be used when an intervention occurred for the sake of society or the community at large, but private necessity on the other hand can be raised as a defence where the interests of another person or a limited group of persons are involved. Lastly, therapeutic necessity is a defence used where an intervention occurred against a patient's will and the violation of autonomy was for the patient's own sake. Therapeutic necessity and therapeutic privilege are discussed below.

It seems that the defence of necessity, more specifically, public necessity, is more relevant to in hospital situations rather than the pre-hospital environment. In the medical profession, the society's best interests can usually only be protected by treating patients with possible contagious diseases or where it is necessary for justice to prevail.³¹⁹ In the pre-hospital environment, it is near impossible to diagnose a patient with what seems to be an infectious disease. It could however be argued that in a case where an EMS provider highly suspect or is informed by a relative that a patient could be suffering from some sort of contagious disease which could be harmful to the society if not treated, that he or she can transport that patient against his or her will in order to ensure that the patient is ultimately diagnosed and treated accordingly. In a case like this, where the patient was also *compis mentis*, the defence of necessity could be used as a ground of justification for transporting a patient to hospital against their will. The circumstances of each case will without a doubt have to be taken into account and EMS providers should not take this path without justifiable suspicions.

³¹⁷ The Medical Law Society of South Africa, *Course 1: Fundamental Principles of Medical Malpractice Law*. <http://medicallawsociety.co.za/wp-content/uploads/2014/11/CPD-Questionnaire.pdf> (Accessed 12 March 2016).

³¹⁸ Carstens and Pearmain (2007) 909.

³¹⁹ See *Minister of Safety and Security v Gaqa* 2002 JDR 0212.

2.3 Therapeutic Necessity/Privilege

Therapeutic necessity describes a situation of medical interventions against a patient's will, whereas therapeutic privilege refers to the situation of withholding certain information to protect the patient.³²⁰

The essential requirements of therapeutic necessity are as follows:³²¹

1. The intervention is urgent.
2. There is no alternative to deal with the emergency.
3. Material information has already been disclosed.
4. The patient refused treatment.
5. The patient's judgment is clearly clouded.
6. The intervention is in the patient's best interests.

The essential requirements of therapeutic privilege on the other hand are as follows:³²²

1. It is clear that the disclosure will harm the patient.
2. Any proposed intervention concerning which information is withheld, is urgently necessary and it is an emergency situation.
3. Any proposed intervention is clearly in the patient's best interests.
4. In the case of any proposed intervention, the patient did not indicate that he or she would not undergo any interventions harboring the type of risks that are now not being disclosed.

Therapeutic privilege is the exception to the rule of full disclosure and obtaining consent for necessary treatment. This principle should be used with caution, as it will not be allowed to be abused as a justification to not obtain informed consent.³²³ This principle will be applied by health care professionals when they feel that it is not in the patient's best interest to provide all information about the patient's diagnosis and

³²⁰ *Id* 910. See Steyn LLM Dissertation 93-94. See also Coetzee LLM dissertation 78 where Coetzee prefers the term "therapeutic justification", but settles on "therapeutic privilege", because the term is universally accepted in medical law.

³²¹ Steyn LLM Dissertation 97.

³²² *Id* 101. See also Coetzee LLM dissertation, 2001, 95-100.

³²³ Dutton (2015) 58.

treatment of a condition. A doctor must err on the side of safety before choosing this path, because if the application of therapeutic privilege is not justified, it will result in the patient not giving informed consent which could lead to liability for assault.³²⁴ South African legal opinion has been undivided in its acceptance of the view that information may be withheld from patients under exceptional circumstances, if the non-disclosure would be in the best interests of the patient.³²⁵

A. Edwin wrote the following in an article, *Don't Lie but Don't Tell the Whole Truth: The Therapeutic Privilege - Is it Ever Justified?*

While some courts have recognized the therapeutic privilege as a way of promoting patient wellbeing and respecting the Hippocratic dictum of “primum non nocere” {or first do no harm}, my position is that this is not ethically justifiable. Since information is a powerful tool for both harm and good, consciously withholding information from competent patients disempowers them and requires greater justification than patient welfare.³²⁶

According to A. Edwin, the court accepts the principle of therapeutic privilege because it is aimed at withholding certain information in order to prevent harm and suffering to the patient, but he feels that withholding information from a competent patient is not legally or ethically defensible as this does not benefit them in the long run.³²⁷

As mentioned in Chapter Three, the concept of informed consent was secured in the case of *Castell v De Greef*³²⁸ and thus, *Castell* indicates that there is no reasoning in raising the therapeutic privilege even when the doctor thinks that the patient will most likely reject treatment.³²⁹

³²⁴ McQuoid Mason & Dada (2011) 418.

³²⁵ Van den Heever *Therapeutic Privilege in the South African Medical Law* (LLM Dissertation. UCT 1997). See also Milner 1957: 384; Burchell 1986: 300; McQuoid-Mason and Strauss LAWSA 17 1983: 149; Strauss 1978: 14; Van Oosten 1991: 33; Claassen and Verschoor 1992: 71.

³²⁶ Ghana Med J. 2008 Dec; 42(4): 156–161. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2673833/> (Accessed 10 January 2016).

³²⁷ *Ibid.*

³²⁸ *Castell v de Greef* 1994, (4) SA 408 (C).

³²⁹ n 326.

When therapeutic privilege is assessed it seems that this principle is only applicable on doctors and does not affect any other health care professionals. However, in the pre-hospital environment, EMS providers are sometimes faced with situations where it will cause more harm in telling a patient the truth about their condition, and thus consent will not be obtained in full before treatment is given. This will be for example where a patient is in a hysterical state after being involved in a serious MVA, and informing him or her about their condition and the necessary treatment will only worsen the situation. The same goes for therapeutic necessity, where a patient that is not of sound mind because of a very traumatic experience, refuses emergency treatment that is clearly in the patient's best interests after all information have been disclosed. With this in mind, it could be argued that therapeutic privilege/necessity should be directly applicable on the pre-hospital setting and EMS providers in order to protect them against allegations of not obtaining informed consent or treating a patient with clouded judgment against his or her direct refusal. Because of the fact that in these cases, it would have been an emergency situation where time is of the essence and it is not good for a patient to receive upsetting information while they are already in shock, the chances that EMS providers will be held accountable on the grounds of not obtaining consent in these situations will most likely be little to none.

It essentially seems that the therapeutic privilege/necessity is more justifiable in an immediate emergency situation than in a situation where information is withheld from a stable patient regarding his or her diagnosis and treatment in order to protect the patient psychologically so that they won't refuse much needed treatment. Usually in a serious emergency, a fully awake and competent patient will already be in shock or a panicking state. By informing them about the potential danger of their condition and the treatment needed will not only affect their psychological state but also affect their physical wellbeing negatively and potentially complicate life-saving interventions, which could cause the patient's death within moments.

2.4 Statutory Authority

Another powerful defense as a ground of justification is that the medical intervention was performed under the authorisation of a statute. The defense of statutory authority may overlap with the defense of necessity and consent, and thus it is possible for a healthcare provider to have multiple defenses for the same medical intervention.³³⁰

According to the common law, people will not be held liable for wrongful acts or omissions if they are exercising a statutory authority.³³¹ Statutory authority may be raised as defense if a) the statute authorises the infringement; and b) the conduct did not exceed the authority directed by the statute.³³² In the case of *Minister of Safety and Security v Gaqa*,³³³ the court ordered the removal of a bullet from an accused's leg against his will, for the purpose of evidence in court proceedings.

Van Oosten and Strauss identified different instances in which statutory authority may justify medical interventions. The first example is where the patient's consent is irrelevant. The *Gaqa* case is a good example of this, or where failure to treat a patient will result in serious risk to public health, or disclosures of suspected child abuse etc. Another example is where the patient cooperates and statutory provisions justifies the medical intervention, thus in those cases, the justifications of statutory authority and consent overlaps. Lastly in some cases, statutory provisions justify medical interventions in emergency situations, in which case the justification of statutory authority and necessity overlaps.³³⁴

In the pre-hospital environment, it is very unlikely that the defense of statutory authority will be relevant. A good example where it most certainly will be relevant on its own is in cases of suspected child abuse or the abuse of elderly. It can also be argued that statutory authority could be relevant in those cases where necessity or consent as defenses are applicable, but in those cases, necessity or consent will most likely be used as the most suitable defenses in the pre-hospital environment

³³⁰ Carstens and Pearmain (2007) 917.

³³¹ McQuoid-Mason and Dada (2011) 369. See also *Government of the Republic of South Africa v Basdeo* 1996 (1) SA 355 (A).

³³² *Ibid.*

³³³ *Minister of Safety and Security v Gaqa* 2002 JDR 0212.

³³⁴ Carstens and Pearmain (2007) 917,918. See also Van Oosten *International Encyclopaedia* para 143 and Strauss *International Encyclopaedia* para 150.

rather than the defense of statutory authority. A detailed assessment of statutory authority is beyond the scope of this dissertation.

2.5 *Boni Mores*

Boni Mores can be seen as the good morals of society as a whole which is formed by legal convictions of the community. *Boni Mores* is often used by courts to determine whether or not a person's actions are wrongful or not and all healthcare providers should always ask themselves if their actions and treatment are in line with the *Boni Mores* of society.³³⁵

According to Carstens and Pearmain, the grounds of justifications mentioned above are not a closed list. The courts are free to extend the grounds of justifications for new situations that may arise should the present justifications be inadequate. This should be done in accordance with the *Boni Mores* or public policy. The ultimate question in those cases will be whether or not the relevant medical intervention was unreasonable (*contra bonos mores*) in terms of society's notions of what might or might not be expected of medical practitioners in the same circumstances.³³⁶

Boni Mores applies to the medical field as a whole and thus any action or omission by EMS providers will also be judged against the morals of society if it becomes relevant in a legal battle.

2.6 Error of Professional Judgment and Medical Misadventure

These defences will refute fault and may thus only operate as defences against professional medical negligence. An error of professional judgment will only succeed if it is clear that another competent physician in the same circumstances would also

³³⁵ McQuoid-Mason (2011) 54.

³³⁶ Carstens and Pearmain (2007) 937.

have made such an error of professional judgment and thus the ordinary test for negligence is employed.³³⁷

In the case of *Whitehouse v Jordan*³³⁸ the court stated the following,

(T)o say that a surgeon committed an error of clinical judgment is wholly ambiguous, for while some such errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising clinical judgment may be so glaringly below proper standards as to make the finding of negligence inevitable.³³⁹

In the pre-hospital environment, errors of professional judgment is just as probable as in any other medical field. In a case where an EMS provider makes an error of professional judgement, his or her actions will be compared to the actions of a competent BLS, ILS or ALS provider in the same circumstances in order to see if the error was excusable and thus not negligent. The courts recognise that doctors and other health care professionals are human beings, and that it is human to err, but that some mistakes lie past the bounds of the standard which is expected of the reasonable and sensible health care professional.³⁴⁰

Because of the unique environment EMS providers work in, it could be argued that errors of professional judgment could occur more than in other branches of the medical field because of the fact that decisions and actions occur in a much quicker time frame and unregulated environment than in other medical settings. It is therefore very important to take in account all the particular circumstances of each case when it comes to errors of professional judgment.

³³⁷ *Id* 940. See also Chapter 9, para 9.6.9 and 9.6.13.3.1.

³³⁸ *Whitehouse v Jordan* (1981) 1 All ER 267 at 276 H.

³³⁹ Dutton (2015) 109.

³⁴⁰ *Ibid.*

3. Comparative Law

In this section, the researcher discusses the EMS of the USA and the EMS of Australia. A brief history of the EMS is given and the structure of the EMS as a whole is discussed. The most important part of this section is how the EMS is regulated in those countries from a legal point of view and the legal protection of the EMS providers as well as case law. The researcher looked at the USA because of the fact that their EMS structure has a lot of similarities compared to the EMS of South Africa. The EMS of South Africa is currently also undergoing changes with regards to the qualifications which will make it even more similar to that of the USA. The EMS of Australia on the other hand has a lot of differences when compared to the EMS of South Africa when looking at the qualifications and the structure of the EMS as a whole.

3.1 The EMS of the United States of America

3.1.1 Structure of the EMS

The first civilian ambulance service was created by the Commercial Hospital of Cincinnati in 1865.³⁴¹ The population of the USA can be characterised as very diverse and the EMS in the USA are no different. The USA follow an Anglo-American model of EMS and the EMS is not uniform throughout the different jurisdictions of the country.³⁴² Just as in South Africa, the EMS was strictly a load-and-go system years ago and the ambulance attendants were only trained in basic first aid. EMS was mainly provided by fire departments, hospitals, small private EMS companies and even funeral homes. There has been a rather dramatic change in the EMS system,

³⁴¹ Page and Vazquez *Analysis of Emergency Medical Systems Across the World* Interactive Qualifying Project, Worcester Polytechnic Institute, 2013. 43. See also Pozner, Zane, Nelson, and Levine *International EMS Systems: The United States: past, present, and future. Resuscitation* (60) 2014. 239-244.

³⁴² *Id* 46.

especially from a training and equipment point of view, but the management structure has not changed much seeing as it is still the fire departments, hospitals and private EMS companies who mainly provide the service.³⁴³ A survey of EMS systems was conducted in 2003 by the National Association of State Emergency Medical Services Directors (NASEMSD) and the Health Resources and Services Administration (HRSA). The survey indicated that 45% of EMS systems were Fire Department based, 6.5% were hospital based and 48.5% were labelled as neither.³⁴⁴

In the 1960's there was a rapid improvement in the EMS system.³⁴⁵ Health care providers were being trained in the importance of CPR, defibrillation, cardio version and other pharmaceutical therapies and these techniques were accepted by the American Heart Association and the American Red Cross. Advances in trauma care also took place and trauma centers were developed.³⁴⁶ Since then the capabilities of the EMS grew tremendously.

In the USA there is a BLS level and an ALS level of care. The BLS is provided by the Emergency Medical Technician-Basic (EMT-B) and ALS is provided by the Emergency Medical Technician-Intermediate (EMT-I) and the Emergency Medical Technician-Paramedic (EMT-P). There is no national license for these qualifications and thus the training and certification is controlled by each state separately and qualifications and scopes do vary between different states.³⁴⁷ The EMT-B scope of practice can be compared to that of a BAA in South Africa. It includes patient assessment, basic airway management, CPR and automated defibrillation, administration of oxygen, immobilization, splinting, bleeding control and occlusion of sucking chest wounds. An EMT-I on the other hand adds ALS skills for trauma

³⁴³ Scott *Emergency Medical Services in the United States of America in 1995* Emergency care information centre, Carlsbad, CA, May 1995. <http://www.emsmuseum.org/virtual-museum/history/articles/403116-Emergency-Medical-Services-in-the-United-States-of-America-in-1995> (Accessed 15 April 2015).

³⁴⁴ Future of Emergency Care, *Emergency Medical Services: At the Crossroads*, Committee on the Future of Emergency Care in the United States Health System Board on Health Care Services, Institute of Medicine of the National Academics. 2007. See also AAA. 2006. *Ambulance Facts*. <http://www.the-aaa.org/media/Ambulance-Facts.htm>. (Accessed 15 April 2016).

³⁴⁵ Shah *The Formation of the Emergency Medical Services System* Am J Public Health, 2006 414. See Also MS Eisenberg *Life in the balance: Emergency Medicine and the Quest to Reverse Death* New York 1997.

³⁴⁶ *Ibid.*

³⁴⁷ n 343. See also Page and Vazquez *Analysis of Emergency Medical Systems Across the World* Interactive Qualifying Project, Worcester Polytechnic Institute, 2013. See also Pozner et al (2004) 239-244.

patients as well as cardiac arrest patients to the EMT-B scope. This includes IV therapy, defibrillation and some medications which includes Lidocaine and Epinephrine. The EMT-I qualification has a lot of variations in the different states and has some differences when compared to the AEA from South Africa which is an ILS level of care. An EMT-P is the highest qualification in the EMS and can be compared to the ECT, CCA or the ECP of South Africa. This level of care also has a lot of variation just like the EMT-I in the different states of the USA. The scope of an EMT-P broadly consists of 12 lead ECG interpretations, Thrombolytics, Endotracheal Intubation, Surgical Cricothyrotomy and the administration of various medications.³⁴⁸ As mentioned in Chapter Two of this dissertation, South Africa's EMS is currently undergoing changes which will make their EMS qualifications even more similar to that of the USA.

In other states the level of qualifications are categorised under Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT) and Paramedic. An EMR has very basic training and usually provides treatment before an ambulance arrives just like a first aider would. An EMT has BLS training much like the EMT-B and an AEMT has training in certain aspects of ALS care and can be compared to the EMT-I. The paramedic, like the EMT-P is the most qualified with extensive training in ALS level of care.³⁴⁹ The *National EMS Scope of Practice Model* defines and describes these four levels of EMS licensure.³⁵⁰ Each state has their own license requirements subject to the states laws and regulations and each state controls the functions and abilities of their EMS providers and for this reason there are quite some variations from state to state.³⁵¹

Generally, ambulances are staffed with at least one ALS provider, which means at least an EMT-I or EMT-P. In some large urban areas like New York, the system of a BLS and an ALS ambulance is used.³⁵² This is different from South Africa where there is seldom an ALS provider on an ambulance. The EMS in South Africa make

³⁴⁸ *Ibid.*

³⁴⁹ Pollak *et al* *Emergency Care and Transportation of the Sick and Injured* AAOS 2011, 5,6.

³⁵⁰ *National EMS Scope of Practice Model*. The National Highway Traffic Safety Administration. <http://www.ems.gov/education/EMSScope.pdf> (Accessed 16 April 2016).

³⁵¹ Pollak *et al* (2011) 9.

³⁵² n 343.

use of response cars for ALS providers in order to minimize response times to serious emergencies.

In most states, the communication system between the public and a dispatch system is called a public safety access point. These communication centers can dispatch fire, police, rescue and EMS and can be reached by dialing 911. Trained personnel will then obtain the necessary information and dispatch the resources needed by following strict dispatch protocols. In some states or areas, different published emergency numbers are used to call for EMS.³⁵³

3.1.2 Regulation of the EMS

In 1966 a White Paper³⁵⁴ was released that revealed to the public and the congress the serious lack of pre-hospital care and transportation. Two Federal agencies were mandated to deal with these issues. These agencies were the National Highway Traffic Safety Administration (NHTSA) of the Department of Transport (DOT), through the Highway Safety Act of 1966 and the Department of Health and Human Services, through the Emergency Medical Act of 1973. These agencies created funding and developed the systems of the pre-hospital emergency care. In the 1970's the DOT developed a curriculum used as guidelines for EMT training. The fact that the responsibilities of the EMS was assigned to the DOT and not the Department of Health was a sign that EMS was primarily seen as a transport service and not a medical service.³⁵⁵

A national standard curriculum was developed for the training of EMS providers in the late 1970's. This curriculum was enhanced in the 1980's by adding ALS care. In the 1990's NHTSA approached the EMS from a national perspective and an *EMS Agenda for the Future* was created which included a plan to standardise the levels of

³⁵³ Pollak *et al* (2011) 15. See also Shah *The Formation of the Emergency Medical Services System* Am J Public Health, 2006.

³⁵⁴ Also called the *Accidental Death and Disability: The Neglected Disease of Modern Society*. See Committees on Trauma, Shock, and Anaesthesia, Division of Medical Sciences. *Accidental Death and Disability: The Neglected Disease of Modern Society*. Washington DC: National Academy of Sciences-National Research Council; 1966.

³⁵⁵ Shah *The Formation of the Emergency Medical Services System* Am J Public Health, 2006.

EMS education and ensure a more unified delivery of EMS throughout the country.³⁵⁶

The NHTSA created the *National EMS Scope of Practice Model*. This model provides guidelines as to the protocols of each EMS provider and these guidelines are intended to create a more consistent delivery of EMS across the country. At state level, laws are enacted to regulate the EMS and each state has EMS administrative offices that regulate licensure. The local medical director can decide limits of EMS providers, for instance which medications are allowed to be carried on an ambulance. A medical director can limit EMS providers' scope of practice, but cannot expand it. The National Registry of Emergency Medical Technicians (NREMT) is a nongovernmental agency that provides standardised EMS certification and many states use the NREMT to certify their EMT's.³⁵⁷ In 46 States, the certification of the NREMT is a prerequisite to practice.³⁵⁸

A lot of changes have occurred in the EMS since 1973, especially with regards to the levels of training and technologies available. The federal role in the EMS has decreased tremendously to a new role by the NHTSA.³⁵⁹ The Omnibus Budget Reconciliation Act of 1981 changed the funding structure of the EMS and integrated EMS programs into the Health Prevention Block grants which have decentralised EMS systems to individual states and thus the variation between EMS regions.³⁶⁰

As mentioned earlier, the NHTSA created the *EMS Agenda for the Future*. This report created a vision of an EMS system which forms part of the Health Care

³⁵⁶ Pollak *et al* (2011) 9. See also Caroline Nancy Caroline's *Emergency Care in the streets* 2008 AAOS; Future of Emergency Care, *Emergency Medical Services: At the Crossroads*, Committee on the Future of Emergency Care in the United States Health System Board on Health Care Services, Institute of Medicine of the National Academics. 2007.

³⁵⁷ Pollak *et al* (2011) 11.

³⁵⁸ *Regulation of Paramedics and Emergency Medical Attendants: A Jurisdictional Review*. Health Professions Regulatory Advisory Council (HPRAC), December 2012. See also National Registry of Emergency Medical Technicians, "Fast Facts".

http://www.nremt.org/nremt/about/NREMT_Fast_Facts.asp (Accessed 16 April 2016).

³⁵⁹ Shah *The Formation of the Emergency Medical Services System* Am J Public Health, 2006. See also *The Forward Plan for the Health Services Administration*. Washington DC: Department of Health, Education and Welfare; 1975.

³⁶⁰ *Ibid*. See also National Committee for Injury Prevention and Control. *Injury Prevention: meeting the challenge*. Am J Prev Med. 1989 276-277; Boyd *The Conceptual development of EMS systems in the United States*: part II. *Emerg Med Serv*, 1982; 11:27-35; Future of Emergency Care, *Emergency Medical Services: At the Crossroads*, Committee on the Future of Emergency Care in the United States Health System Board on Health Care Services, Institute of Medicine of the National Academics. 2007.

system as a whole. *Agenda for the Future* has been placing the EMS in the spotlight and has shed some light on how important the EMS system truly is. The NHTSA has shown significant leadership in the EMS over the past years. They have also been the only federal agency focused on refining the EMS in the USA.³⁶¹

The delivery of EMS and trauma care is largely governed by federal and state legislation which provides protection and structure, but these federal structures also present difficulties and obstacles to achieving quality care. The Emergency Medical Treatment and Active Labour Act (EMTALA) is one of the government's regulatory structures.³⁶² The EMTALA was enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 mainly in response to the concern that emergency departments regularly refuse to treat indigent patients, a practice known as 'patient dumping'.³⁶³ The EMTALA is discussed in Chapter Two under the Emergency Medical Treatment section.

Most states control and govern the EMS and most states have an EMS agency that forms part of the State Health Department, but some state EMS agencies may form part of the Public Safety Department or could even be an independent agency. These agencies oversee local and regional EMS systems and they also license and certify EMS providers.³⁶⁴ Only some of the functions of state agencies include complaint investigations, training standards, disciplinary action, inspections, funding, education, etc.³⁶⁵

³⁶¹ Future of Emergency Care, *Emergency Medical Services: At the Crossroads* (2007) 37.

³⁶² *Id* 48. See also GAO (U.S. Government Accountability Office). 2001a. Emergency Care. EMTALA Implementation and Enforcement Issues. Washington, DC: Government Printing Office.

³⁶³ Pearmain (2004) 305. See also United States General Accounting Office Report to Congressional Committee. Emergency Care: EMTALA Implementation and Enforcement Issues, June 2001, Available at <http://www.cm.taloom>.

³⁶⁴ *Id* 50 See also GAO. 2001b. Emergency Medical Services: Reported Needs Are Wide-Ranging, with a Growing Focus on Lack of Data (GAO-2-28). Washington, DC: Government Printing Office. See also Furrow *et al*, *Health Law Cases, Materials and Problems* 1997 76.

³⁶⁵ *Id* 51 See also Mears 2004; *2003 Survey and Analysis of EMS Scope of Practice and Practice Settings Impacting EMS Services in Rural America: Executive Brief and Recommendations*. Chapel Hill, NC: University of North Carolina at Chapel Hill Department of Emergency Medicine.

3.1.3 Legal Protection of EMS Providers

Years ago there were few concerns about medico-legal issues in the EMS, but this is clearly something of the past. As mentioned previously, the public is becoming more and more aware of the potential liability of pre-hospital providers and their administrators, and thus EMS providers today should be informed about legal issues surrounding the EMS in order to escape liability.

In the USA, every single state has passed some sort of legislation that grants immunity for liability for individuals rendering emergency medical care in an emergency situation.³⁶⁶ The *Good Samaritan Doctrine* is present in all states as a common law concept and by 2007 all states had codified this judicial doctrine in their legislation. This doctrine allows medical professionals who acted as Good Samaritans in an emergency situation to shield themselves from liability during a medical negligence claim. This doctrine is an after-the-fact means of protecting Good Samaritans. This means that *Good Samaritan* laws are retrospective and that there is no guarantee that the statute will cover the action and thus the defense will not automatically prevent a law suit from being filed.³⁶⁷ In order for Good Samaritans to avoid liability, they cannot seek compensation, act recklessly or intentionally do wrong, or act against the wishes of victims.³⁶⁸

Every state has certain limitations applicable on the *Good Samaritan Doctrine*. In some states, *Good Samaritan* laws can only be used by volunteers as a defense while in other states the doctrine is limited to out of hospital emergencies. In Pennsylvania, one part of the *Good Samaritan* Statute covers medically trained personnel and the other part covers lay persons.³⁶⁹ In some states, courts may scrutinize claims that *Good Samaritan* laws also apply to EMS providers with a duty

³⁶⁶ Moore *et al* *Emergency Medical Services EMS and the Law*. Monograph 3, International Association of Fire Fighters IAFF. 1997 3. See also BR Furrow *et al* (1997) 207.

³⁶⁷ Rosenbaum, Harty and Sheer *State Laws Extending Comprehensive Legal Liability Protections for Professional Health-Care Volunteers During Public Health Emergencies*. Public Health Rep. 2008 238–241. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2239336/> (Accessed 17 April 2015). See also Moore *et al* *Emergency Medical Services EMS and the Law*. Monograph 3, International Association of Fire Fighters IAFF. 1997 3.

³⁶⁸ *Ibid.*

³⁶⁹ Moore *et al* (1997) 4.

to provide aid.³⁷⁰ Some of the other limitations for which immunity is granted in some of the states include: if care was given within scope of duties; if care was given gratuitously; if given under imminent threat to life; etc.³⁷¹

On the other hand, there are some states that have enacted statutes that specifically provide immunity for EMS providers. These statutes also vary from state to state. For example, the State of New York's statute only protects volunteer EMT's rendering aid in an emergency, whereas The State of Michigan's statutes protects any public or private EMT.³⁷² In The State of Illinois, all EMS providers acting in the normal course of their duties are protected against liability except if their actions constitute willful and wanton misconduct.³⁷³ Ohio is also a State that provides the same immunity as The State of Illinois and in a specific case in Ohio paramedics were protected because of this immunity after being sued for medical negligence. The paramedics attended to a patient but did not transport him to hospital and although the patient died later that night the court stated that, because Ohio provides immunity for all but "wilful and wanton" conduct by EMS providers, they could not be held liable.³⁷⁴ Some States only provide protection to individuals who provide EMS without compensation.³⁷⁵ An example of compensation will be Medicaid reimbursement to private ambulance services and thus the statutory protections will not apply.³⁷⁶

Other entities may also face liability for actions or omissions of their personnel. Even when EMS professionals individually are protected from civil liability, their employers

³⁷⁰ Hodge *et al* *Expanding the Roles of Emergency Medical Services Providers: A Legal Analysis*, Public Health Law and Policy Programme, Centre for Law, Science and Innovation. Association of State and Territorial Health Officials ASTHO. (2014) 25. See also *Willard v. Vicksburg*, 571 So. 2d 972 (Miss. 1990) (declining to interpret a Good Samaritan statute, but recommending that the legislature review and amend the statute to clarify application to those with a duty to provide care).

³⁷¹ Moore *et al* (1997) See Appendix 1.

³⁷² *Ibid*. See also Morgan *et al* *Liability Immunity as a Legal Defence for Recent Emergency Medical Services System Litigation*. Prehospital and Disaster Medicine, 1985.

³⁷³ Hodge *et al* (2014) 24. See also 210 Ill. Comp. Stat. 50/3.150(a); *Meck v. Paramedic Services of Illinois*, 695 N.E.2d 1321 (Ill. App. Ct. 1998).

³⁷⁴ Maggiore *To Transport or not to Transport? Part 2 of 2 Ems And The Law*. Journal of Emergency Medical Services. Jan 2006. <http://www.jems.com/articles/2006/01/transport-or-not-transport-par-2.html> (Accessed 18 April 2016). See also *Fuson v. City of Cincinnati*, 633 N.E. 2d 612, 91 Ohio App.3d 734 (Ohio App. 1993).

³⁷⁵ Hodge *et al* (2014) 24.

³⁷⁶ *Ibid*. See also *E.g., Martin v. Fulton-DeKalb Hospital Authority*, 551 S.E.2d 415 (Ga. Ct. App. 2001).

may not be.³⁷⁷ While alternative protections may be available for some governmental entities, these protections often do not apply to private-sector employers.³⁷⁸ Prior to 1940, most hospitals were protected by charitable or governmental immunity. This has changed drastically in the following years as most jurisdictions abrogated charitable immunity and although governmental immunity was more resistant to elimination, judicial and legislative actions have left most hospitals responsible for the actions of their employees and as charitable and governmental immunity got abolished, it made space for vicarious liability.³⁷⁹

It should be kept in mind that for a negligence claim to be successful, there has to be a health care provider-patient relationship or in this case an EMS provider-patient relationship and a duty to care.³⁸⁰ The negligence test will also then have to be applied in order to see if the EMS provider could have foreseen and prevented the damages. Doctors and other medical personnel are not liable *per se* for an error of judgement, misdiagnosis or some sort of undesirable result.³⁸¹ Furrow et al stated that the duty of care takes two forms:

- a) a duty to render a quality of care consistent with the level of medical and practical knowledge the doctor may reasonably be expected to possess and the medical judgement he may be expected to exercise, and
- b) A duty based upon the adapt use of such facilities, services, equipment and options as are reasonably available.³⁸²

3.1.4 Case Law

Although not seen in South Africa, the USA provides for quite some medical negligence law suites where EMS providers and their administrators are involved. In

³⁷⁷ Vicarious liability was discussed in Chapter Three and the rules of vicarious liability in the USA are not discussed here.

³⁷⁸ Hodge *et al* (2014) 25.

³⁷⁹ Furrow et al (1997) 240.

³⁸⁰ *Id* 360.

³⁸¹ *Ibid.*

³⁸² *Id* 150.

the case of *Schulman v County of Los Angeles Fire Department/Paramedics*,³⁸³ the plaintiff claimed that the paramedics failed in a grossly negligent manner to properly diagnose and treat the plaintiff based on all relevant information conveyed to them and that this caused a delay in the plaintiff receiving proper treatment which lead to the worsening of her condition.³⁸⁴

The facts of the case are roughly as follows: The plaintiff, a 22 year old female student, went out for a couple of drinks with friends one night. At some stage throughout the night, the plaintiff experienced a sharp pain near her left ear, accompanied with sudden dizziness, disorientation, unintelligible communication, vomiting and loss of consciousness. Her friends phoned 911 and upon the paramedics arrival they assessed her and came to the conclusion that she was showing symptoms of consuming too much alcohol, although her friends did convey all her acute symptoms. She was taken to hospital and at the emergency department the nursing staff received the same message from the paramedics that she merely had too much to drink. Only a few hours later it was concluded that the plaintiff actually had an intracranial bleed which was a life threatening condition. After assessing all the relevant facts, the court came to the conclusion that, the paramedics employed by the defendant, grossly disregarded critical information which had been conveyed to them on the scene by eyewitnesses. All symptoms pointed to an intracranial bleed. The paramedics failed to report the acute onset of severe head pain, disorientation and abrupt personality changes and thus summary judgment was awarded.³⁸⁵

In the *Hackman v American Medical Response*³⁸⁶ case, the court looked at the *Zepeda v City of Los Angeles*³⁸⁷ case and came to the conclusion on appeal that the

³⁸³ *Schulman vs. Regents of UC, et al.* B195349 Court of Appeals of CA, Second Appellate District, Division Two.

³⁸⁴ *Ibid* <http://www.gmsr.com/article/081022SchulmanOpinion.pdf> (Accessed 18 April 2016). See also <http://thelegalguardian.com/schulman-v-county-of-los-angeles-fire-dept-paramedics/> (Accessed 6 June 2015).

³⁸⁵ *Ibid.*

³⁸⁶ *Hackman v. American Medical Response* 2004 WL 823206 (Cal. App. 4 Dist.)

³⁸⁷ *Zepeda v City of Los Angeles* (1990) 223 Cal.App.3d 232.

paramedics in the *Hackman* case breached the duty of care and was thus liable for damages.³⁸⁸

The facts of the case are broadly as follows: Hackman was involved in a MVA. After the incident, bystanders described Hackman as being confused and unstable and phoned 911. The paramedics arrived on scene and after a quick assessment of Hackman, they concluded that Hackman was not injured. Hackman herself also stated that she was fine and did not see the need to go to hospital. Hackman did not sign an Against Medical Advice (AMA) form because the paramedics did not feel the need for her to be transported to hospital. 20 Minutes after the paramedics left, Hackman collapsed and the paramedics had to return and transport her to hospital. Hackman filed a complaint stating that the defendants (the paramedics as well as American Medical Response) acted negligently by leaving her at the scene after assessing her.³⁸⁹

The trial court relied on the *Zepeda* case and granted defendant's motion for summary judgment, because no duty of care was established. In the *Zepeda* case, the court concluded that no duty of care was established because there is no duty on anyone to come to the aid of another, but when someone nevertheless undertakes to come to the aid of another, he or she may be held liable for not acting with the appropriate level of care. In the *Zepeda* case, the paramedics never assessed or treated the patient because they were waiting for the police before entering the scene and thus no duty of care was established. The defendants in the *Hackman* case stated that they owed no duty of care to Hackman and never undertook to provide care to her. Hackman on the other hand argued that even though the paramedics technically had no duty to come to her aid, they arrived on scene and evaluated her condition and thus they did undertake to provide some form of aid to her and therefore owed a duty of care. The appeal court reversed the trial court's judgment and concluded that the paramedics did in fact breach a duty of care

³⁸⁸ *Hackman v AMR* <http://thelegalguardian.com/hackman-v-amr/> (Accessed 12 April 2016). See also Maggiore *To Transport or not to Transport? Part 2 of 2 Ems And The Law*. Journal of Emergency Medical Services. Jan 2006. <http://www.jems.com/articles/2006/01/transport-or-not-transport-par-2.html> (Accessed 18 April 2016).

³⁸⁹ *Ibid.*

because they assessed her on scene before leaving, even though it was merely a visual assessment.³⁹⁰

Just looking at the above cases it becomes very clear that EMS providers are just as vulnerable as any other medical professionals when it comes to medical malpractice litigation and that they should act with the utmost caution when treating and/or transporting or rather not transporting patients.

3.2 The EMS of Australia

3.2.1 Structure of the EMS

The purpose of the EMS in Australia is very similar to that of the USA and South Africa, to provide emergency medical care and to convey the sick and injured. One of the big differences however between the EMS of Australia and that of the USA, is that unlike in the USA, where fire departments have a major role in the provision of EMS, in Australia, the role is assumed by ambulance services.³⁹¹ Even with the growth in paramedic training and qualifications, it remains the case that ambulance services are provided almost exclusively by government operated statutory authorities. Another big difference between the two is the different qualifications found in Australia compared the qualifications in South Africa and the USA.

³⁹⁰ *Ibid.* Any Breach of the duty to care is measured by the standard of care under the *California Health and Safety Code* section 1799.106.

“1799.106. (a) In addition to the provisions of Section 1799.104 of this code, Section 2727.5 of the Business and Professions Code, and Section 1714.2 of the Civil Code, and in order to encourage the provision of emergency medical services by fire-fighters, police officers or other law enforcement officers, EMT-I, EMT-II, EMT-P, or registered nurses, a fire-fighter, police officer or other law enforcement officer, EMT-I, EMT-II, EMT-P, or registered nurse who renders emergency medical services at the scene of an emergency or during an emergency air or ground ambulance transport shall only be liable in civil damages for acts or omissions performed in a grossly negligent manner or acts or omissions not performed in good faith. A public agency employing such a fire-fighter, police officer or other law enforcement officer, EMT-I, EMT-II, EMT-P, or registered nurse shall not be liable for civil damages if the fire-fighter, police officer or other law enforcement officer, EMT-I, EMT-II, EMT-P, or registered nurse is not liable”.

³⁹¹ Hertelendy EMS Down Under Aug, 2005 <http://Www.Emsworld.Com/Article/10323796/Ems-Down-Under> (Accessed 5 May 2016).

Training of the EMS providers in Australia has developed from on the job training provided by state and territory ambulance services to vocational qualifications and more recently higher education qualifications (University). There are different certificates and diplomas which fall under the vocational qualifications and today there are a large number of Universities providing qualifications as paramedics.³⁹²

The EMS services in Australia consist broadly out of the following: Australian Capital Territory Ambulance Service, Ambulance Service of New South Wales, Ambulance Victoria, Queensland Ambulance Service, South Australian Ambulance Service, St John Ambulance - Northern Territories, Tasmanian Ambulance Service and the Western Australian Ambulance.³⁹³

The structure of the EMS in the Australian Capital Territory is as follows: In the case of non-emergency patient transport, you get a Patient Transport Officer (Ambulance Support Officer Level 1). They provide non-emergency patient transport to and from healthcare facilities, clinics and private residences. The Australian Capital Territory Ambulance Service (ACTAS) provides an 18 week training program leading to the qualification of Certificate III in Non-Emergency Client Transport.³⁹⁴

In the case of emergency operations, a qualification of ambulance qualified paramedic or intensive care paramedic is needed. This is the most advanced level of qualification and is used to provide ALS care.³⁹⁵

With the Ambulance Service of New South Wales (ASNSW), the qualifications also range between paramedics, patient transport officers and specialised areas such as intensive care and extended care paramedics.³⁹⁶ They also have a rapid response service consisting of mobile single paramedic units. A Patient Transport Officer on the other hand only transports non-emergency patients. Patient Transport Officers

³⁹² Eburn & Bendall *The provision of Ambulance Services in Australia: a legal argument for the national registration of paramedics* Australian Journal of Paramedicine 2012; <http://ro.ecu.edu.au/jephc/vol8/iss4/4> See also NTIS.gov.au National Training Information Service; Ambulance Victoria, Paramedic University Courses; University of Tasmania, Bachelor of Paramedic Practice-Future Students.

³⁹³ Services in Australia <https://ozambos.wordpress.com/services-in-australia/> (Accessed 7 May 2016).

³⁹⁴ ACT Emergency Services Agency / ACT Ambulance Service / Careers / <http://esa.act.gov.au/actas/careers/non-emergency/> (Accessed 8 May 2016). ACTAS official governmental website.

³⁹⁵ *Ibid.*

³⁹⁶ ASNSW official website. <http://www.ambulance.nsw.gov.au/about-us.html> (Accessed 8 May 2016).

undertake in-house training in basic first aid with advanced resuscitation. They can also administer oxygen, monitor pulse and breathing rates etc., which is very basic first aid.³⁹⁷

In Victoria there are qualified paramedics whom can administer ALS care. This includes intravenous cannula (drips), administer pain relief medication, perform advanced airway management, give intravenous drug therapy for cardiac arrest patients and perform IV fluid replacement for trauma patients. Then there are also mobile intensive care paramedics and air ambulance paramedics that consist of a higher clinical skill set and can perform more advanced medical procedures. They also have ambulance community officers whom can provide BLS care until a paramedic arrives or transport non-emergency patients. Victoria also recruits graduate paramedics who obtained a university degree and can administer ALS care.³⁹⁸

Most of the other states qualifications also consists of paramedics who can administer ALS care and Patient Transport Officers who are only trained in BLS care and assists in non-emergency situations and transports non-emergency patients between facilities.³⁹⁹

These states all consist of ambulances used for the transport of non-emergency patients that are occupied by Patient Transport Officers and on the other hand ambulances for emergency operations occupied by paramedics or intensive care paramedics. Some states make use of single paramedic vehicle units for quicker response times to serious emergencies, just like the response vehicles in South Africa.⁴⁰⁰

³⁹⁷ *Ibid.*

³⁹⁸ Victoria Ambulance Service. Official website. <http://ambulance.vic.gov.au/paramedics/types-of-paramedics/> (Accessed 8 May 2016).

³⁹⁹ See for example the official websites of Queensland Ambulance Service <https://ambulance.qld.gov.au/index.html> (Accessed 8 May 2016), and the official website of South Australian Ambulance Service <http://www.saambulance.com.au/> (Accessed 8 May 2016).

⁴⁰⁰ *Ibid.*, See also n 388,389 and 390.

3.2.2 Regulation of the EMS

The EMS of Australia are regulated by the different states or territories. Australian Capital Territory ambulance services and all other emergency services are established and regulated by the *Emergencies Act 2004*⁴⁰¹. Section 40 and 41 of the Act set out the functions of the ambulance services as well as the constitution of these services. In New South Wales (NSW) the EMS is governed by the *Health Services Act*⁴⁰². The Act regulates the provision of ambulance services in NSW. The Act also established an Ambulance Services Advisory Council, whose function it is to provide advice to the Health Secretary or to an appointed body in relation to the exercise of functions and the provision of ambulance services. In Queensland, it is the *Ambulance Service Act*⁴⁰³ that governs and regulates the EMS. The Act touches everything from the establishment of ambulance services, functions, appointment of a commissioner, the staff of the service, disciplinary actions and administrative powers, through to the protection of ambulance personnel and appointment and functions of investigating officers.⁴⁰⁴

In South Australia the EMS is regulated by the *Health Care Act*⁴⁰⁵. Part six of this Act is established for ambulance services and regulates the provision of ambulance services and miscellaneous acts, such as fees for ambulance services and the power to use force to enter premises. In Tasmania the *Ambulance Service Act 105 of 1982*⁴⁰⁶ governs the EMS. This Act is very similar to the *Ambulance Service Act* of Queensland and also covers the establishment of ambulance services, functions of ambulance services, appointment of a commissioner, staff of the service, disciplinary actions and administrative powers, protection of ambulance personnel, appointment and functions of investigating officers and other miscellaneous acts

⁴⁰¹ *Emergencies Act 2004* A2004-28. <http://www.legislation.act.gov.au/a/2004-28/current/pdf/2004-28.pdf> (Accessed 10 May 2016).

⁴⁰² *Health Services Act 154 of 1997*.
http://www.austlii.edu.au/au/legis/nsw/consol_act/hsa1997161/s67i.html (Accessed 10 May 2016).

⁴⁰³ *Ambulance Service Act 1991* <https://www.legislation.qld.gov.au/legisln/current/a/ambulserva91.pdf> (Accessed 10 May 2016).

⁴⁰⁴ *Ambulance Service Act. Section 3A – Section 100*.

⁴⁰⁵ *Health Care Act 2008*.
<https://www.legislation.sa.gov.au/lz/c/a/health%20care%20act%202008/current/2008.3.un.pdf> (Accessed 10 May 2016).

⁴⁰⁶ *Ambulance Service Act 105 of 1982*. http://www.austlii.edu.au/au/legis/tas/consol_act/asa1982158/ (Accessed 10 May 2016).

such as fees and general offences.⁴⁰⁷ Last but not least, the state of Victoria also has an *Ambulance Service Act*.⁴⁰⁸ The Act describes the functions and powers of the ambulance service, it regulates the board of ambulance services and it also describes how to create, modify and abolish an ambulance service. This is only to mention a few.

3.2.3 Legal Protection of EMS Providers

The *New South Wales Health Services Act* states the following:

67I Exculpation from personal liability

A member of staff of the Ambulance Service of NSW or an honorary ambulance officer is not liable for any injury or damage caused by the member of staff or officer in the carrying out, in good faith, of any of the member's or officer's duties relating to:

- (a) the provision of ambulance services, or
- (b) the protection of persons from injury or death, whether or not those persons are or were sick or injured.⁴⁰⁹

The *Queensland Ambulance Service Act of 1991* states the following:

Division 6 Protections 36V Protection from liability

(1) A person who is or was a member of an RCA team, or relevant person for an RCA team, is not civilly liable for an act done, or omission made, honestly and without negligence under this part.

⁴⁰⁷ *Ambulance Service Act 105 of 1982 Part I – Part IV.*

⁴⁰⁸ *Ambulance Service Act 1986.* http://www.austlii.edu.au/au/legis/vic/consol_act/asa1986176/ (Accessed 10 May 2016).

⁴⁰⁹ *Health Services Act 154 of 1997.* Section 67I. http://www.austlii.edu.au/au/legis/nsw/consol_act/hsa1997161/s67i.html (Accessed 12 May 2016).

(2) Without limiting subsection (1), if the act or omission involves giving information—
(a) in a proceeding for defamation, the person has a defence of absolute privilege for publishing the information; and (b) if the person would otherwise be required to maintain confidentiality about the information given under an Act, oath, or rule of law or practice, the person— (i) does not contravene the Act, oath, or rule of law or practice by giving the information; and (ii) is not liable to disciplinary action for giving the information.

(3) If a person who is or was a member of an RCA team, or relevant person for an RCA team, incurs costs in defending proceedings relating to a liability against which the person is protected under this section, the person must be indemnified.⁴¹⁰

In *Tasmanian the Ambulance Service Act 1982* - Section 41 states the following:

41. Protection from liability

(1) An officer of the Ambulance Service, or a volunteer ambulance officer acting under the authority of this Act, does not incur any civil or criminal liability in respect of any act done or omitted to be done by the person in good faith –

(a) in providing ambulance services or a prescribed activity; or

(b) in the performance or exercise, or the purported performance or exercise, of any function or power under this Act; or

(c) in the administration or execution, or the purported administration or execution, of this Act.

(2) Subsection (1) does not apply to the provision of non-emergency patient transport services unless those services are provided by an officer of the Ambulance Service while he or she is operating in that capacity.⁴¹¹

⁴¹⁰ *Queensland Ambulance Service Act of 1991*. Division 6.

<https://www.legislation.qld.gov.au/legisltn/current/a/ambulserva91.pdf> (Accessed 12 May 2016).

⁴¹¹ *Ambulance Service Act 1982*. Section 41.

http://www.austlii.edu.au/au/legis/tas/consol_act/asa1982158/s41.html (Accessed 12 May 2016).

Exemptions of liability portrayed in the above acts are not the only legislation that protects health care professionals and volunteers from liability. In Australia, just like in the USA, there are *Good Samaritan* laws and nearly all Australian states and territories have *Good Samaritan* legislation in place to protect those who assist others in emergency situations, provided they act in good faith. Examples of these legislations are the *Civil Laws (Wrongs) Act 2002* (ACT) s 5; *Civil Liability Act 2002* (NSW) s 57; *Personal Injuries (Liabilities and Damages) Act* (NT) s 8; *Civil Liability Act 1936* (SA) s 74; *Civil Liability Act 2002* (Tas) s 35B; *Wrongs Act 1958* (Vic) s 31B; and the *Civil Liability Act 2002* (WA) s 5AD).⁴¹²

The *Civil Liability Act 2002* of New South Wales states the following:

A Good Samaritan does not incur any personal civil liability in respect of any act or omission done or made by the Good Samaritan in an emergency when assisting a person who is apparently injured or at risk of being injured.⁴¹³

In the case of *Mid Density Developments Pty Limited v Rockdale Municipal Council*,⁴¹⁴ the court attempted to describe the meaning of 'good faith' and came to the conclusion that good faith means an act done *bona fide* and not maliciously. It also means that the function should not be performed without caring whether or not it is properly performed.

The IPP Review into the Law of Negligence final report stated that under the current law, the fact that someone acted in an emergency is relevant in deciding whether the person acted negligently or not. This is applicable on any person including health care professionals. Some risks taken in an emergency would not be seen as a

⁴¹² Eburn, Australian Emergency Law: *Good Samaritan legislation and scope of practice*. March 2015. <https://emergencylaw.wordpress.com/2015/03/27/good-samaritan-legislation-and-scope-of-practice/> (Accessed 13 May 2016).

⁴¹³ *Civil Liability Act of 2002* (NSW) Section 57. *Ibid.*

⁴¹⁴ *Mid Density Developments Pty Limited v Rockdale Municipal Council*[1993] FCA 408. *Ibid.*

reasonable risk to take in a non-emergency situation. They do, however, also mention that precautions should be taken to prevent the risk materialising.⁴¹⁵

In the case of *Ambulance Service of NSW v Worley*,⁴¹⁶ a paramedic was held to have been negligent in the District Court after administering treatment to a patient suffering from anaphylaxis which caused an intracranial haemorrhage with severe consequences. The Court of Appeal reversed the District Court's finding.

The protocol stated that adrenaline should only be administered if the patient is in extremis, which according to the trial Judge meant 'on the point of death'. The trial Judge found that the paramedic was negligent for choosing to administer the relevant drug without considering whether the patient was truly at the point of death or not. He felt that each officer has a set of protocols and each officer is required to follow those protocols without any discretion to do otherwise. In the Court of Appeal however, they said that what the paramedic did was to apply the protocols according to their terms and that that course was in accordance with the training he received. The paramedic was expected to administer that treatment and paramedics are not trained or expected to make a "fine evaluation of alternative treatments."⁴¹⁷

Although paramedics can also be accused of negligent conduct and get dragged into legal battles, paramedics predominantly operate as employees, and as mentioned before, according to the doctrine of vicarious liability, the employers are liable for any negligent conduct caused by their employees in the course of their duties.⁴¹⁸

⁴¹⁵ *Ibid.* See Also IPP Review of the Law of Negligence, Final Report (Commonwealth of Australia, 2002), [7.21]-[7.24]).

⁴¹⁶ *Ambulance Service of NSW v Worley* [2006] NSWCA 102; Eburn *Australian Emergency Law: Treatment outside the protocol*. April 2012. <https://emergencylaw.wordpress.com/2012/04/02/treatment-outside-the-protocol/> (Accessed 15 May 2016).

⁴¹⁷ *Ibid.*

⁴¹⁸ The Senate. Legal and Constitutional Affairs References Committee. *Establishment of a national registration system for Australian paramedics to improve and ensure patient and community safety*. Final report. May 2016, p19. <http://www.bnhcrc.com.au/aggregator/sources/1> (Accessed 24 May 2016).

3.2.4 National Registration System

Currently, there is no national registration or accreditation system for paramedics in Australia. The Legal and Constitutional Affairs References Committee structured a report and made recommendations with regards to the establishment of a National Registration System for Australian paramedics to improve and ensure patient and community safety.⁴¹⁹

In Australia, paramedics and the work they do are relatively unregulated. Paramedics are mostly restricted with regards to scheduled drugs, which are regulated by the employers. Other than that, paramedics are allowed to do whatever they are competent to do as long as the quality of their treatment is reasonable. If not, they could be held liable for negligence. The only states and/or territories who has laws as to who a 'paramedic' is or what the term 'paramedic' actually mean, is South Australia, Tasmania and NSW. In essence there is no law in Australia that explains and stipulates what paramedics may or may not do.⁴²⁰

The Health Services Amendment (Paramedics) Bill 2015 states that:

67ZDA Holding out as paramedic

- (1) A person who is not a paramedic must not, in any way, hold himself or herself out to be a paramedic.

Maximum penalty: 100 penalty units.

- (2) For the purposes of this section, a paramedic is:

- (a) a person who holds qualifications, or who has received training, or who has experience, prescribed by the regulations, or

- (b) a person who is authorised under the legislation of another Australian jurisdiction to hold himself or herself out to be a paramedic, or

⁴¹⁹ *Ibid.*

⁴²⁰ Eburn: *Australian Emergency Law | Bushfire & Natural.*

<http://www.bnhcrc.com.au/aggregator/sources> (Accessed 24 May 2016).

- (c) a member of staff of the Ambulance Service of NSW, or other person, who is authorised by the Health Secretary to hold himself or herself out to be a paramedic.⁴²¹

The Health Services Amendment (Paramedic Qualifications) Regulation 2015 (NSW) Bill defines the qualifications required to use the title 'paramedic'. The Regulation states:

The following qualifications are prescribed for the purposes of section 67ZDA (2) (a) of the Act:

- (a) a Bachelor of Paramedicine or a Graduate Diploma of Paramedicine conferred by a university,
- (b) a nationally-recognised Diploma of Paramedicine issued by a registered training organisation.⁴²²

In Australia, paramedicine varies from jurisdiction to jurisdiction and lacks a uniform standard of what a paramedic is and what qualifications are needed to be seen as a qualified paramedic.⁴²³ Australia is looking to establish a National Registration and Accreditation System (NRAS) which includes the establishment of a paramedic board operating in conjunction with the NRAS and administered by the Australian Health Practitioner Regulation Agency (AHPRA).⁴²⁴ The skills of paramedics have developed tremendously over the years and procedures undertaken by paramedics are often complex and advanced. As we also know, paramedics usually operate in remote locations without the assistance of medical doctors and the resources available in hospitals. The Australian Medical Association (AMA) stated that

⁴²¹ *Ibid.* *The Health Services Amendment (Paramedics) Bill 2015* Section 67ZDA(1) and (2). See also <http://www.austlii.edu.au/au/legis/nsw/bill/hsab2015330/> (Accessed 29 May 2016).

⁴²² *The Health Services Amendment (Paramedic Qualifications) Regulation 2015* (NSW). Division 2A, Section 19A(1)(a) and (b). <http://www.legislation.nsw.gov.au/regulations/2015-811.pdf> (Accessed 29 May 2016). See also [Eburn: Australian Emergency Law | Bushfire & Natural. http://www.bnhcrc.com.au/aggregator/sources](http://www.bnhcrc.com.au/aggregator/sources)

⁴²³ n 418. See also Mr Martin Nichols, Chair, Board of Directors, Australian and New Zealand College of Paramedicine (ANZCP), *Committee Hansard*, 20 April 2016, p. 39.

⁴²⁴ *Ibid.*

paramedics are regarded as making a vital contribution to the Australian healthcare system.⁴²⁵ It is because of the above reasons that it is quite evident that the paramedic profession in Australia is in need of a better regulatory system in order to advance the profession and to protect the public. This would also create a better system for the public to complain about the treatment by paramedics, as the current situation only enables patients and the public to complain directly to the employer. There is simply no public register where people can lodge complaints about bad service and substandard treatment by paramedics.⁴²⁶

The Australian Health Practitioner Regulation Agency (AHPRA) is a commonwealth government agency that regulates health professions in Australia through its administration of the National Registration and Accreditation Scheme (NRAS).⁴²⁷

The NARS protects the public, develops the health workforce and regulates multiple health professions which each has their own national board. The Royal Flying Doctor Service of Australia (RFDS) mentioned that the paramedic profession should be added to the list of professions regulated by NRAS and made the following accurate statement:

(I)t is time that paramedicine was properly respected in Australia as a profession on par with that of medicine and that of nursing...As an employer, we want to know that across the nation there is a standard of care that we can expect, demonstrated through prequalification and through continuous professional development, but, most importantly, we also want to know that there is a system of monitoring a nationally consistent standard.⁴²⁸

There is an overwhelming support for such a NRAS and the Legal and Constitutional Affairs References Committee believes that there is a strong case for the implementation of such. The Committee recommends the establishment of a

⁴²⁵ *Ibid.* See also Associate Professor David Mountain, Emergency Physician Representative, Australian Medical Association (AMA), *Committee Hansard*, 20 April 2016, p. 11.

⁴²⁶ n 415, See also Associate Professor Michael Eburn, Australian National University (ANU), *Committee Hansard*, 20 April 2016, p. 3.

⁴²⁷ *Ibid.*

⁴²⁸ *Ibid.* See also Mr Martin Laverty, Chief Executive Officer, Royal Flying Doctor Service of Australia (RFDS), *Committee Hansard*, 20 April 2016, p. 33.

National Registration System and believes that it could possibly be implemented as of mid-2018.

4. Conclusion

In this chapter, the grounds of justification for medical interventions were discussed and analysed with regards to the pre-hospital environment. As mentioned before, when a medical intervention is performed in the absence of a ground of justification, it is *prima facie* unlawful as it creates a violation of the patient's rights enshrined in the Constitution. The grounds of justifications most relevant to the pre-hospital environment were looked at and it is quite clear that those justifications, especially the justification of *negotiorum gestio* and necessity, will provide just as much protection to EMS providers than to any other health care provider working in a hospital setting. After assessing therapeutic necessity and therapeutic privilege, it became quite evident that these principles are in a sense more relevant to an emergency in the pre-hospital environment or in an emergency department than a situation where a patient is in need of urgent medical assistance, but is in a stable condition in hospital.

A justification, such as Statutory Authority on the other hand, probably won't be used in the pre-hospital setting as often because of the fact that this justification frequently overlaps with justifications such as necessity and consent which are more applicable on emergency situations outside of hospital. Because of the unique environment EMS providers work in, it could be argued that errors of professional judgment, which is also a ground of justification, could occur more than in other branches of the medical field because of the fact that actions and decisions occur in a much quicker time frame and unregulated environment than in other medical settings. Although paramedics in South Africa are highly trained, it cannot be expected of paramedics to make a fine evaluation of alternative treatments such as can be expected of medical doctors.

Although in South Africa there hasn't been much litigation where EMS providers are involved as yet, it is good to know that the South African law will provide a form of

protection through the grounds of justifications in medical law to those who can potentially become part of a legal battle where medical negligence is suspected. Although South Africa doesn't have *Good Samaritan* laws or separate legislation directly applicable on the EMS in the pre-hospital setting, these common law principles will most likely provide enough protection to those who acted as any other reasonable EMS provider in the same circumstances would have acted.

This Chapter broadly assessed the EMS of the USA and the EMS of Australia. The whole structure of the EMS of the USA is more comparable to the EMS of South Africa, whereas Australia differs quite a lot. In all of the countries however, the goal of the EMS is the same and over the years the qualifications and skills of EMS providers has improved tremendously.

In the USA, each state has their own license requirements subject to the laws and regulations of each state and each state controls the functions and abilities of their EMS providers. In Australia, the different states and territories has legislation which regulates the EMS and thus there is also no uniform EMS system in Australia. This is quite different from South Africa, where the same requirements, qualifications and regulations are applicable over the whole country and the EMS is regulated by an Emergency Care Practitioners board through the HPCSA. The USA has however through the *EMS agenda for the future* and the National Highway Safety Administration, aimed at creating a more consistent delivery of EMS and standardising the levels of education throughout the country. In Australia there is an attempt to create a National Registration System in order to regulate the EMS system more effectively, as the EMS of Australia at this stage is quite an unregulated profession. It is believed that this will advance the profession and protect the public.

In both the USA and Australia, there are *Good Samaritan* laws and other legislation which protects EMS providers against liability. EMS providers in South Africa on the other hand do not have *Good Samaritan* laws and legislation specifically created for the EMS to protect them and thus they need to rely on the common law principles and grounds of justification in medical law. It would create more clarity if the National Health Act is amended in order to include EMS providers directly with regards to protection against liability in emergency situations in the pre-hospital setting.

Chapter 5

Conclusion and Recommendations

1. Regulation of the EMS of South Africa

It is quite evident that the EMS is very different from any other profession and an average or normal day for EMS providers is most certainly not normal for the average man on the street. The pre-hospital environment is filled with uncertainty, adrenaline, dangers, frustrations and the satisfying feeling of assisting others in true emergencies. One can only imagine how difficult it is to regulate such a system in order for it to operate smoothly and effectively in a country like South Africa. Chapter Two dealt with the structure of the EMS of South Africa and the pre-hospital environment, as well as the regulation of this unique profession.

As mentioned in Chapter Two, the EMS is regulated by the NHA, the HPA, the HPCSA and the Professional Board for Emergency Care, as well as provincial legislation such as the Gauteng Ambulance Services Act.⁴²⁹ These legislative frameworks and governing bodies regulate everything from the different qualifications and training to the protocols, management, limitations, and the rights and responsibilities of EMS providers. Although there are several Acts, legislative frameworks and regulations that control and manage the EMS, there are still substantial grey areas when it comes to certain medico-legal situations that EMS providers have to deal with in their careers, and unfortunately we are in dire need of a regulatory framework that addresses these unique situations adequately and directly in order to give more legal clarity in this profession.

When thinking long term, a comprehensive national EMS Act, which addresses all those grey areas and uncertainties such as informed consent, restraining of patients, abandoning of patients, DNR's etc., sounds like the most effective solution, but creating legislation is a very time consuming process and thus there is a need for

⁴²⁹ n 32,33,48,64.

some sort of guidelines provided by the HPCSA and the Professional Board for Emergency Care to create a form of clarity with regards to those complex situations EMS providers face on a daily basis. More detailed recommendations are provided in the sections below.

2. Emergency Medical Treatment

As seen in Chapter Two, the definition of emergency medical treatment, or rather the lack of a definition or term, affects the EMS directly which in turn leads to ethical and practical difficulties. It is not an easy term to define as the medical field is extremely broad and it is impossible to create a definition for emergency medical treatment or a medical emergency that caters for every situation and every other person's perception of what an emergency is.

Although a better definition will most likely solve some difficulties experienced in the EMS, it will not unravel all the grey areas and challenges EMS providers struggle with on a daily basis. At the end of the day, it starts with adequate education with regards to the EMS system as a whole and how it should be used. In other words, the public has to be educated as to what a medical emergency truly is in order to reduce the exploitation and misuse of the system and to know how to use the EMS optimally.

The definition of emergency medical treatment stands between two essential aspects. One being the fact that certain injuries and illnesses left out of the definition will be perceived as medical emergencies by many and the other that the availability of resources has to be kept in mind, as a too broad definition will put tremendous strain on an already struggling primary health care system.

Sadly, with South Africa's primary health care system taking so much strain and the fact that there aren't nearly enough resources to handle all the sick and injured, the definition for a medical emergency or emergency medical treatment given by the Constitutional Court, which excludes terminal illnesses, is the most suitable definition at this stage.

3. Challenges in the Pre-Hospital Setting

One of the first problems in the EMS mentioned in Chapter Three is the fact that there are so many EMS companies who do not meet the required standards set out by the EMS Regulations. This without a doubt affects patient safety which is the most important aspect and function of the EMS. Those regulations are provided to ensure that the EMS of South Africa is up to standard and that it provides an effective and safe service to the public. Unfortunately, because of the fact that the private EMS developed into a very competitive industry, it is extremely difficult for the ambulance services to adhere to all the standards and requirements while trying to treat and transport as many paying medical aid patients as possible. The fact that most of the public ambulance services are not up to standard is a total different story and is not discussed further.

It will be quite a challenge to implement a system where all the ambulance services, both public and private, are inspected unannounced on a regular basis in order to determine whether or not they have all the necessary equipment on their vehicles, their vehicles are correctly marked and licenced and that all their personnel are trained and qualified according to national standards. Unfortunately this is the only way to truly regulate the EMS and to ensure public safety, although it is impossible to control what happens on accident scenes. It is a scary reality, based on practical experience and knowledge of the required standards that a tremendous amount of ambulance services will be closed down or suspended if such inspections had to take place. The EMS Regulations states in Section 16(1)(a) that,

The Head of Department will, at least once in every calendar year, inspect or cause to be inspected by a duly authorised inspecting officer, every emergency medical service registered in terms of these Regulations.⁴³⁰

It is unclear whether all registered ambulance services are inspected annually as should be the case according to the EMS regulations.

In Chapter Three the test for negligence was provided and discussed.⁴³¹ Negligence without a doubt also occurs in the pre-hospital setting and if someone's injuries are

⁴³⁰ n 66.

worsened by the wrongful and negligent actions of EMS providers, they will have to endure the consequences just like any other medical professional in hospital. However, if one takes into account the circumstances that EMS providers work in, the question arises if negligence could be expected in certain situations, or rather if a bigger margin of error should be considered when assessing negligence in the EMS setting. As stated earlier, although the EMS providers of South Africa are highly trained and qualified, it cannot be expected of them to make a detailed assessment of alternative actions and treatment such as can be expected of medical doctors.

As discussed in Chapter Three, Carstens and Pearmain stated that medical negligence can never be separated from the particular circumstances of a case. This principle is often referred to as 'concrete negligence'. In essence, this means that when a practitioner's conduct is assessed with regards to negligence, all the circumstances, including the locality; the facilities available; financial resources; difficult conditions or emergency situations and the nature of the medical intervention have to be taken into consideration.⁴³²

It was also argued above that the *Locality rule* should be directly applicable on the EMS because when the pre-hospital environment is assessed, it could be reasoned that although the EMS providers working in this unique environment are trained to deal with emergencies outside of hospital, the pre-hospital environment as a whole cannot be compared to that of a private hospital, or any hospital for that matter, and thus the environment should also be taken into consideration when assessing EMS providers alleged negligence. In the case of the EMS, the locality will not necessarily be based on a rural area without supporting facilities in comparison with a hospital in Cape Town, but rather a dangerous or hazardous environment, like a mine or a patient trapped somewhere on a cliff or in a burning vehicle, in comparison with a normal in-hospital situation.

Although it could be argued that the pre-hospital environment plays an important role, EMS providers has to remember that patients' rights and patient safety are very highly valued and they should do the necessary to ensure that they treat patients

⁴³¹ n 93.

⁴³² n 158.

according to the required standards and protocols, act when there is a duty to do so, never practice outside of their scope of practice, and always act in good faith in order to ultimately avoid liability. Keeping this in mind, the *Imperitia Culpa Adnumeratur* rule states that a medical practitioner who engages in treatment that requires a certain degree of skill, training, knowledge and experience, while he or she is aware of the fact that he or she does not consist of such skill, training, knowledge and experience, will be bound by his or her treatment accordingly with regards to medical negligence. In South Africa however, the chances of being held accountable for damages after acting in good faith in an emergency, even if it was outside of the relevant professional's scope of practice, is little to none.⁴³³

With regards to the various grey areas in the pre-hospital environment, there is a need for guidelines to shed some light on medico-legal issues that EMS providers face all too often. In the pre-hospital environment, EMS providers face issues of consent on a regular basis. These situations, without a doubt, differ from situations in hospital and because of various difficulties experienced in the pre-hospital setting, EMS providers can be uncertain whether or not they should accept a patient's refusal or act against their will. Unfortunately, there isn't specific legislation applicable to the pre-hospital environment alone. The general rules of consent and informed consent are applicable on the EMS just as it is applicable on any other medical profession. A set of guidelines specifically drafted for the EMS on how to deal with consent issues in specific practical situations will help tremendously in order for EMS providers to ensure that they handle each unique situation to the best of their abilities and to make sure that they avoid any form of liability.

The Professional Board for Emergency Care should provide a set of case analyses which should form part of the training of all EMS providers in order to shed more light on how challenging consent situations should be handled. A type of standard form or list which includes all necessary steps to take when confronted with a patient that refuses treatment and transport can assist to ensure that EMS providers has covered themselves when leaving a patient behind after a refusal. A good example of such list or form is that used by The County of San Mateo EMS set out in Chapter

⁴³³ n 161, 167.

Three.⁴³⁴ Such type of check sheet can be developed and used with regards to many other grey areas in the EMS. An example would be where EMS providers are confronted with a DNR patient or a mental health care patient. Different check sheets applicable on different scenarios in the pre-hospital environment can assist EMS providers so that they know where to start, what questions to ask, the major do's and don'ts, and to ensure that they escape liability regardless of the outcome, as long as they followed the prescribed protocol for that specific situation. Ultimately it would be best if some of the guidelines, with regards to different pre-hospital challenges, could manifest into legislation and form part of a national EMS Act.

With regards to DNR's, there is no policy or specific guidelines for out-of-hospital DNR orders, nor any out-of-hospital DNR order forms, which leaves EMS providers with very little legal clarity on this specific topic. In Chapter Three, an example was given of what an out-of-hospital DNR policy should consist of.⁴³⁵ Such a policy would shed light on how to handle patients with DNR's in the pre-hospital environment and would assist EMS providers so that they would know what to look for and to help them to make a quick and informed decision whether to resuscitate a patient or not. At the end of the day, such policy should be recognised by legislative measures if possible in order to create more legal certainty.

Another complicating issue dealt with by EMS providers is the restraining of patients, competent as well as mental health care patients. EMS providers are regularly confronted with aggressive patients or patients who do not consist of sufficient mental capacity to make informed decisions about their health care and are thus a potential threat to themselves and the people around them. Unfortunately, in these type of situations, EMS providers often have to go to extreme measures in order to assist and treat those patients. As seen earlier, the MHCA does not make provision for the EMS, which technically makes any restraining of patients outside of hospital by EMS providers, against the law.⁴³⁶ The Regions Hospital Emergency Medical Services in the USA has a set of guidelines to use in cases where a patient has to be restrained by EMS providers outside of hospital. These guidelines were provided in

⁴³⁴ n 231.

⁴³⁵ n 244.

⁴³⁶ n 268.

Chapter Three.⁴³⁷ Until the MHCA is amended to make provision for the EMS, such guidelines should be provided by the HPCSA in order for EMS providers to understand how to best approach restraining situations in the pre-hospital environment.

This dissertation created a clear picture of the different medico-legal challenges faced in the EMS and the fact that there are little to no guidance by the legislator or any other regulatory body as to how such situations should be addressed to avoid liability. It is quite evident that the EMS is in serious need of a regulatory framework that provides guidelines and protocols as a start until legislation is produced to address these unique issues. Sadly the public is becoming more and more aware of the potential liability of the EMS, which should act as more reason to create guidelines and legislation for the EMS.

4. Grounds of Justification for Medical Interventions

In our law, very often medical professionals have to make use of a ground of justification for a medical intervention in order to protect themselves from liability. The different grounds of justifications were mentioned in Chapter Four and the ones most applicable on the EMS were analysed. The question was whether or not these justifications are directly applicable on EMS providers and the pre-hospital environment as a whole.

As mentioned in Chapter Four, when a medical intervention is performed in the absence of a ground of justification, it is *prima facie* unlawful or wrongful as it creates a violation of the patient's rights enshrined in the Constitution.⁴³⁸ Unauthorised administration; necessity (including therapeutic necessity and therapeutic privilege); Statutory Authority; *Boni Mores*; and error of professional judgment and medical misadventure were discussed. It became clear that the defense of unauthorised administration is valuable in the pre-hospital setting because it can be used as a defense in situations where patients are injured or ill to an extent where it is impossible for them to give their consent to receive lifesaving treatment, whether it is

⁴³⁷ n 275.

⁴³⁸ n 295.

because of unconsciousness or because the patient is in such a state of shock that he or she is not thinking clearly.⁴³⁹ Necessity, or rather public necessity, is more applicable on in hospital situations where the society as a whole has to be protected. Private necessity on the other hand could be used by EMS providers in defense of their own or a third party's legally recognised interest, which is threatened with immediate harm.⁴⁴⁰ When therapeutic privilege/necessity was discussed, it became clear that those principles could possibly be more applicable on the pre-hospital setting and emergency situations, than on a normal in hospital situation. Thus, it could potentially be a good defense for an EMS provider to use when important information was withheld from a patient or where the EMS provider acted against a refusal after all information was disclosed.⁴⁴¹

Statutory authority was also briefly mentioned and it seems that an example where it most certainly will be relevant on its own is in cases of suspected child abuse or the abuse of elderly. It can be argued that statutory authority could be relevant in cases where necessity or consent as defenses are applicable, but in those cases necessity or consent will most likely be used as the most suitable defenses in the pre-hospital environment.⁴⁴² Lastly *Boni Mores* and error of professional judgment and medical misadventure was discussed. *Boni Mores* applies to the entire medical field and thus any action taken by EMS providers will be judged against the morals of society if it becomes relevant in litigation.⁴⁴³ When it comes to error of professional judgment, the test for negligence applies and the question will be asked whether or not another reasonable EMS provider would have acted the same in those circumstances. The courts do however take in to account that all medical professionals are human and that it is human to err, but there is of course a line and not all errors can be excused. In the case of errors of professional judgment, all relevant circumstances should also be taken into account and once again the question is asked whether or not it is more excusable if an error occurs in an unpredictable and unregulated pre-hospital environment.⁴⁴⁴

⁴³⁹ n 296, 297

⁴⁴⁰ n 305, 306, 307, 308, 309.

⁴⁴¹ n 313,314, 315, 316, 317, 318, 319, 320, 321.

⁴⁴² n 323, 324, 325, 326, 327.

⁴⁴³ n 328,329.

⁴⁴⁴ n 330, 331, 332.

After assessing the different grounds of justifications, it can be said without a doubt that these justifications, some more than others, are directly applicable on EMS providers and the pre-hospital environment and that it will certainly provide a form of protection when EMS providers are confronted with professional negligence or assault allegations.

5. Comparative Law

In this dissertation, the researcher assessed the EMS of the USA and Australia respectively. The goal of the comparative section was to give an overall idea of how the different EMS systems operate in comparison with the EMS of South Africa. Another very important aspect that the researcher looked at was how the EMS of the USA and Australia are regulated in terms of their legal systems and what type of protection the law provides to EMS providers. After assessing these systems it was clear that the EMS of Australia and the USA are regulated by means of legislation. Every state or territory has their own legislation specifically created for the ambulance services or has a section in a Health Act created for the emergency services which is quite comprehensive. The legislation touches every legal aspect with regards to the EMS. As mentioned above, the EMS of South Africa has so many unanswered questions and grey areas which ask for a regulatory framework addressing these issues. An EMS Act and guidelines which gives answers to questions such as consent, restraining of patients, refusal of treatment and/or transportation, DNR orders etc. will assist EMS providers and provide more clarity as to how certain situations should be handled in order to make quick decisions and in the process avoid any liability.

The legislation of Australia covers the establishment of ambulance services, functions of ambulance services, appointment of a commissioner, staff of the service, disciplinary actions and administrative powers, protection of ambulance personnel, appointment and functions of investigating officers and other miscellaneous acts such as fees and general offences. The Acts also addresses important issues such as protection from liability. All those issues in South Africa are

dealt with in the EMS Regulations as well as Acts such as the Gauteng Ambulance Services Act, except for protection from liability, which is not addressed. Unlike Australia's EMS, South Africa's EMS also falls under the HPCSA of South Africa and thus there is a national registration and accreditation system for paramedics in South Africa which ensures patient and community safety and explains what EMS providers may or may not do. As mentioned above, in the USA the National Highway Traffic Administration (NHTSA) regulates the EMS and each state also has their own laws regulating the EMS. Just as with Australia, these laws mostly address the functions and administrative aspects of the EMS and in most cases protection against liability.

What is thus needed is not legislation and guidelines addressing the normal issues of licencing, functions, staff, administrative powers etc. but rather legislation and guidelines addressing the medico-legal issues EMS providers face while attending to patients as well as protection against liability. The fact that South Africa has no provincial EMS Act which addresses protection against liability, or *Good Samaritan* laws or any mention of liability in the EMS regulations, leaves EMS providers with little legal certainty in these cases as the common law principles, of which EMS providers won't necessarily have much knowledge of, will be applicable. Ultimately, South Africa needs to enact comprehensive legislation that overhauls the entire EMS system.

6. Final Conclusion

As a final conclusion, the researcher has set out some recommendations to address the current issues experienced in the EMS.

With regards to consent issues, the researcher recommends that the Professional Board for Emergency Care creates guidelines and case analyses. The case analyses can be based on situations that EMS providers have previously dealt with in their careers and then give answers as to how to handle such situations to avoid liability. The Professional Board can also provide guidelines or a standard check

sheet as to which questions to ask when someone refuses treatment and/or transport and the EMS provider is uncertain as to whether the refusal should be accepted or not. These case analyses and guidelines should be compulsory in the study material of all EMS courses.

Many EMS providers do not understand the importance and value of documentation. The Professional Board for Emergency Care should provide guidelines as to what should be written down in any medical report so that EMS providers can go back to their paperwork and answer any questions that might come up in disciplinary proceedings or a legal battle. These guidelines should also address refusal of treatment documentation in order for EMS providers to know how a refusal should be documented.

As mentioned previously, restraining of patients by EMS providers is technically not legal. The Mental Health Care Act only makes provision for the SAPS to restrain a person. The MHCA should be amended in the future to include EMS providers with regards to restraining of patients. The Professional Board for Emergency Care should also provide guidelines as to how such situations should be approached by EMS providers. For instance, who should be contacted before a patient is restrained, the necessary boxes to tick before the decision to restrain a patient can be made, and which measures of restraining to use with different patients etc.

In the case of DNR orders, legislation is needed to address all the issues for both in hospital DNR issues as well as out of hospital DNR issues. The legislation should stipulate what treatment falls under the term 'Do Not Resuscitate', what should be looked for in DNR documentation to see if it is valid or not, should CPR be initiated until the DNR order is confirmed, does a living will have to include a DNR order in order for CPR to be withheld pre-hospitally, does a DNR order expire, what should be done if the patient has a DNR order but the family insists that CPR should be performed, can a healthy person request a DNR order or is it only applicable in cases where CPR would be futile, and lastly, is a DNR order only applicable on natural deaths and would a suicide attempt thus nullify a DNR order. These are just some of the issues that have to be addressed in the legislation in order to create more legal clarity. As mentioned earlier, an out-of-hospital DNR policy can also

assist greatly and provide guidance in situations where EMS providers are faced with patients who have DNR orders.

Last but not least, protection against liability should also be addressed in legislation. This can possibly form part of the NHA under the emergency medical services section or as part of the different Provincial Ambulance Services Acts. Clarity should be given with regards to the protection of lay persons, trained volunteers and employed EMS providers in emergency situations.

After the completion of the task of analysing the EMS in South Africa, it became evident that the EMS is a unique, unpredictable but poorly regulated field in the medical profession which is in dire need of more research which can ultimately provide the field of the EMS with answers, guidelines, regulations and most importantly, legislation. One can only hope that in the future the EMS will get the legal attention it deserves.

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