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Hackland, Stuart George

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MORAL OBLIGATION OR MEDICAL OBSTACLE: IS THE PATIENTS' RIGHTS CHARTER FIT FOR PURPOSE IN THE PREHOSPITAL EMERGENCY SETTING?

Stuart George Hackland

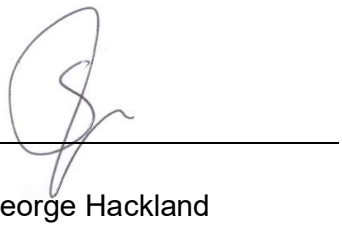
Student Number: 1761718

A Research Report submitted to the Faculty of Health Sciences, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Masters of Science in Medicine in Bioethics and Health Law.

Johannesburg, March 2021

Declaration

I, Stuart George Hackland, declare that this Research Report is my own, unaided work. It is being submitted for the degree of Masters of Science in Medicine in Bioethics and Health Law at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



Stuart George Hackland

21st day of March 2021 in Johannesburg.

Dedication

This work is dedicated to my wife, Tina, and my two boys, Andrew and John,

With grateful appreciation for your prayer, support and encouragement, but chiefly for your unwavering love. I am what I am because of you.

Secondly, this work is dedicated to the thousands of South African emergency medical care workers who, day after day, night after night, place themselves in harm's way because of their belief in the value of human life and their desire to relieve suffering and offer hope. This country is all the better because of your tireless, selfless, and often thankless, service.

Abstract

Humans, by virtue of their humanity, possess an intrinsic dignity. This dignity deserves respect, and that respect manifests in the allocation of rights. In South Africa, these rights include the right of access to healthcare. The National Department of Health, in their mandate to promote, protect and fulfil this right of access to healthcare, published their National Patients' Rights Charter (PRC) in 1999. It comprises approximately twenty-five rights a patient may expect from the healthcare system.

However, the PRC is unsuitable for application in the prehospital emergency environment, where the setting is uncontrolled, time-pressured, and occupied with providing life-saving care to the highest acuity patients, for whom the slightest delay may prove fatal.

In this research report I apply the ethical theory of *Prima Facie* Duty to argue that, in life-threatening emergencies, the paramedic is morally justified in withholding certain patients' rights in favour of providing life-saving treatment and transport. As an alternative to the PRC, I formulate the *Patients' Emergency Rights Charter (PERC)* tailored to the dynamic circumstances of the prehospital emergency setting in South Africa.

Acknowledgements

My thanks to my supervisor, Dr Anthony Egan SJ, for his support in this work and his gracious understanding of the complexities of juggling life with studies.

Table of Contents

Declaration ii

Dedication iii

Abstract iv

Acknowledgements v

Table of Contents vi

List of Tables ix

List of Figures and Boxes ix

Nomenclature x

Abbreviations xiii

CHAPTER 1 : Introduction 1

1.1 Introduction 1

1.2 Background Literature Analysis and Critique 1

1.3 Research Question 3

1.4 Rationale for Study 3

1.5 Thesis 5

1.6 Research Aim 5

1.7 Research Objectives 6

1.8 Research Design and Methods 6

1.9 Argumentative Strategy 7

1.10 Research Outcomes 8

1.11 Limitations 9

1.12 Overview of Chapters 9

1.13 Conclusion 10

CHAPTER 2 : The South African National Patients' Rights Charter 11

2.1 Introduction 11

2.2 History and context of the PRC development 11

2.3 Equivalent international patients' rights charters 13
2.4 The aims and functions of the PRC 13
2.5 The PRC's basis in law 15
2.6 The PRC's basis in morality 15
2.6.1 Moral, human and legal rights 16
2.6.2 Claim-rights 16
2.6.3 Power-rights 17
2.6.4 Liberty-rights 17
2.6.5 Active, passive, positive and negative rights 17
2.6.6 Human rights' generations 18
2.7 Overview and structure of the PRC 18
2.8 Application of the PRC 23
2.9 General concerns 24
2.10 A return to the PRC's aims and function 26
2.11 Premise 27
2.12 Conclusion 27
CHAPTER 3 : The nature of Emergency Medical Services and emergency medical conditions 28
3.1 Introduction 28
3.2 Pertinent definitions 28
3.3 A brief description of the South African EMS 29
3.4 The pre-hospital emergency setting 32
3.5 Commonly encountered patients 33
3.6 Emergency medical conditions 36
3.6.1 Types of emergency medical conditions 36
3.6.2 Severity of emergency medical conditions 38
3.6.3 Severity triaging tools 39

3.6.4 Patient prioritisation 40
3.7 Premises 41
3.8 Conclusion 42
CHAPTER 4 : A normative analysis of applying the Patients' Rights Charter in the prehospital emergency setting. 43
4.1 Introduction 43
4.2 Life: the essential condition for all future rights accrual 43
4.3 The trouble with Rights in the Emergency 44
4.4 *Prima Facie* Duties 47
4.5 Application of *Prima Facie* Duties to the Patient's Rights Charter 50
4.6 Premise 55
4.7 Conclusion 56
CHAPTER 5 : The Patients' Emergency Rights Charter 57
5.1 Introduction 57
5.2 The Patients' Emergency Rights Charter 57
5.3 "Weighing-up" and application of the PERC 60
5.4 Conclusion 63
CHAPTER 6 : Conclusion 64
References 67
Appendix A: The South African Patients' Rights Charter 79
Appendix B: Ethics Waiver 80
Appendix C: Turnitin Report 81

List of Tables

Table 2.1: Analysis of the Patients' Rights Charter ……. 20-22

Table 3.1: Sample of South African EMS qualifications ……. 31

Table 3.2: Comparison of pre-hospital and in-hospital settings ……. 34-35

Table 3.3: Examples of critical conditions and injuries requiring immediate treatment ……37

Table 3.4: Examples of emergency conditions with increasing severity or maximal severity from outset ……. 39

Table 3.5: Example of prioritisation based on the severity of a patient's injury/illness ……..40

Table 4.1: Correlation of Patients' Rights Charter rights to *Prima Facie* duties …… 51

List of Figures and Boxes

Box 4.1: The Paramedic Oath ……..... 51-52

Figure 4.1: Interactions of *Prima Facie* duties in the life-threatening emergency … 54

Box 5.1: The Patients' Emergency Rights Charter ……..……..58-60

Figure 5.1: The Emergency Severity Index Conceptual Algorithm ……..……..61

Nomenclature

Cardiac (or cardiopulmonary) arrest – The cessation of functional cardiac activity (i.e. the heart stops beating) which results in no blood-flow through the cardiovascular system of the person. In cardiac arrest, the patient is recognised as clinically dead, although not in the physiological- or legal sense. The condition is potentially reversible depending on the causative factor, but only if treated immediately within the first few minutes of pulselessness, otherwise irreversible organ damage incurs and permanently prevents any subsequent physiological resuscitation.

Circulatory shock – a reversible but potentially life-threatening condition where the patient's cardiovascular system is unable to maintain sufficient perfusion (blood flow) to the body's tissues, resulting in decreased oxygen delivery and subsequent tissue/organ damage. It has several aetiologies, and uncorrected shock will lead to cardiac arrest.

Claim-right - a right where the right-holder (the beneficiary of the right) is guaranteed of something through the mandatory action/inaction (the reciprocal duty) of another party (the duty-bearer). Thus, wherever someone has a justifiable claim, there must exist a second party who is obligated to facilitate the realisation of that right, or else the right is imaginary.

Critical care – the medical management of a patient during times when the patient is most at risk of sustaining serious harm or death due to the progression of physiological derangements from an injury or acute or chronic illness. This management includes resuscitation, stabilisation and continuation of the treatment required to sustain homeostasis. Critical care may occur in emergency departments, intensive care units or in the prehospital emergency setting.

Hohfeldian incidents – "The four basic components of rights, [named] after Wesley Hohfeld (1879–1918), the American legal theorist who discovered them. These four basic 'elements' are the privilege, the claim, the power, and the immunity. Each of these Hohfeldian incidents has a distinctive logical form, and the incidents fit together in characteristic ways to create complex 'molecular' rights" (Wenar, 2015:2).

Homeostasis – “the ability or tendency of a living organism, cell, or group to keep the conditions inside it the same despite any changes in the conditions around it, or this state of internal balance” (Cambridge Advanced Learner's Dictionary, 2019).

In-hospital / in-facility clinical setting - medical services offered in a variety of facilities such as hospitals, primary healthcare clinics, mobile clinics, doctors/dentists consulting rooms, physiotherapists’ practices, etc. The facility has been purposefully designed to offer a specific medical service and benefits from an integration of multi-disciplinary medical and secondary support services.

Liberty-rights (or privilege-rights) – a right that exists in the “absence of a duty to abstain from [an] action” (Lazarev, 2005:np). Put another way, someone has the liberty to do or have something iff they do not have an express prohibition on doing or having that thing (Wenar, 2015:2).

Patient acuity – “In emergency and critical care medicine, the severity of a hospitalized patient's illness and the level of attention or service he or she will need from professional staff” (Taber’s Medical Dictionary, 2021).

Peri-arrest – the period immediately before cardiac arrest occurs, when the patient’s physiological compensatory mechanisms malfunction and then cease altogether, thereby heralding cardiac arrest.

Power-right – a right to legitimately alter the rights (claims, liberties or powers) of others (Wenar, 2015:4).

Prima facie – “at first sight”; “based on what seems to be the truth when first seen or heard” (Cambridge Advanced Learner's Dictionary, 2019).

Prima Facie Duties – a set of non-hierarchical, deontological-type duties proposed by W.D. Ross, which were morally binding unless it became circumstantially apparent that other duties were weightier. He called these “*prima facie* duties” because they appeared at first to be the obvious incumbent duties, but which may be displaced on careful reflection by other (possibly conflicting) duties. These other, weightier duties become the “duty proper” or the morally binding duty (Ross, 1930:19).

Prehospital (or pre-hospital) clinical setting – the setting in which emergency medical care is provided by professional paramedics, usually within an ambulance system, at the site of sustaining an injury or illness, and includes the transportation of the patient to the hospital facility. This environment includes the home, school, office, retail premises, industrial and agricultural facilities, sports fields, roadsides, wilderness, aboard sea vessels, etc. The setting is uncontrolled, dynamic and potentially hazardous, thus vastly complicating the provision of emergency care and transport.

Respiratory failure – a derangement of the respiratory system causing inadequate exchange of respiratory gasses (oxygen and carbon dioxide), resulting in hypoxaemia (low blood-oxygen levels), hypoxia (low tissue-oxygen levels), and respiratory acidosis. If uncorrected, respiratory failure may lead to shock, respiratory arrest, and ultimately cardiac arrest.

Respiratory arrest – a cessation of breathing, causing profound hypoxaemia, and if uncorrected, circulatory shock and then cardiac arrest.

Right – that which is considered by most people of a society to be morally good, fair or acceptable (Cambridge Advanced Learner's Dictionary, 2019).

Rights – “those things that one is morally or legally entitled to do or have” (Collins English Dictionary, 2020).

Abbreviations

ACHPR – African Charter for Human and People's Rights of 1981

AEA – Ambulance Emergency Attendant

ALS – Advanced Life Support

B.Tech.:EMC – Bachelor of Technology in Emergency Medical Care

BAA – Basic Ambulance Attendant

BEMC – Bachelor of Emergency Medical Care

BLS – Basic Life Support

BOR – South African Bill of Rights

CCA – Critical Care Assistant

CDC – Centers for Disease Control and Prevention

CPR – Cardiopulmonary resuscitation

CVS – Cardiovascular system

DoHET – Department of Higher Education and Training

ECP – Emergency Care Practitioner

EMS – Emergency Medical Services

EMSSA – Emergency Medicine Society of South Africa

ENA – Emergency Nursing Association

ESI – Emergency Severity Index

HCP – Healthcare Provider

HIV/AIDS – Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

HPCSA – Health Professions Council of South Africa

ICCPR – UN International Covenant on Civil and Political Rights of 1966

ICESCR – UN International Covenant on Economic, Social and Cultural Rights of 1966

ICU – Intensive Care Unit

ILS – Intermediate Life Support

ITLS – International Trauma Life Support

IV – Intravenous

NDH – National Department of Health

NGSA – National Government of the Republic of South Africa

NHA – National Health Act No. 61 of 2003

NQF – National Qualifications Framework

OUNHCHR – Office of the United Nations High Commissioner of Human Rights

PBECP – Professional Board of Emergency Care Practitioners

PERC – Patients' Emergency Rights Charter

PFD – *Prima Facie* Duty(ies)

PRC – South African Patients' Rights Charter

RSA – Republic of South Africa

RTS – Rapid Trauma Survey

TRC – Truth and Reconciliation Commission

UCT – University of Cape Town

UDR – United Nations Universal Declaration of Human Rights of 1948

UN – United Nations

WHO – World Health Organisation

WMA – World Medical Association

CHAPTER 1: Introduction

1.1 Introduction

The South African National Patients' Rights Charter (PRC) (National Department of Health, 1999b) may be considered as a practical extension of the Bill of Rights (National Government of South Africa, 1996). The charter was published in 1999 by the National Department of Health (NDH), and sought to lay "a common standard" (NDH, 1999b:1) to ensure the right of access to healthcare services. Whilst not at the level of a regulation (but rather a policy-type document), the charter's introduction compels "Practitioners [to] adhere to the stipulations of this charter" (NDH, 1999b:1), thereby implying a weight of obligation in upholding and ensuring those rights to their patients.

Whilst I applaud the spirit and intention of the PRC, I am concerned that it is limited in its applicability to certain settings within the healthcare system, especially in regard to the Emergency Medical Services (EMS). In this research report, I intend to examine its suitability in the emergency setting, and if it is unsuitable, contemplate the moral argument for not applying it prehospitally in its current form under certain circumstances.

In this chapter, I will examine the available literature on patients' rights and their provision and protection in the emergency medical setting. I will then state my research question and propose my thesis along with its aims and objectives. I will describe the research design, research methods and intended outcomes, and conclude with an overview of the remining chapters of the research report. The full Patients' Rights Charter may be found in appendix A.

1.2 Background Literature Analysis and Critique

Chapter 2 of the Constitution of the Republic of South Africa (National Government of South Africa, 1996), entitled the Bill of Rights (BOR), expresses the human rights to be "respect[ed], protect[ed], promote[d] and fulfil[led]" (Sec. 7(2)) by the State. Section 27, occupied with healthcare amongst other rights, states that "everyone has the right

to have access to… healthcare services" (Sec. 27(1) & (1)(a)). This is echoed by other international declarations (United Nations, 1948), charters (Organisation of African Unity, 1981), and local legislation (National Government of South Africa, 2004).

It is in regard to "the right of access to health care services" that the South African National Patients' Rights Charter positions its purpose: "as a common standard for achieving the realisation of this right" (NDH, 1999b:1). Similar charters and declarations to define and protect patients' rights have proliferated internationally (WHO, 2018; Rider & Makela, 2003).

However, section 36 of the Bill of Rights introduces the allowance that rights may be limited. These limitations may only occur "in terms of law of general application to the extent that the limitation is reasonable and justified in an open and democratic society" (Sec. 36(1)) and continues to list a number of considerations to be made in sanctioning a limitation. Undoubtedly section 36 is aimed at lawmakers and law enforcers, and is occupied with the first generation rights espoused within the BOR itself, but the fundamental principle (that under certain conditions rights are not assured) is important when considering the second generation rights ascribed by a policy document such as the Patients' Rights Charter.

An exhaustive search of academic resources reveals that the PRC has not been analysed in the light of the prehospital emergency setting, although literature exists on specific rights in the emergency (Kramer, 2008; Erbay, 2014), and much has been written on rights waivers in emergency clinical trial research (Bhutta, 2004; Foëx, 2014; Morrow, Argent & Kling, 2015). There are also some studies examining the knowledge and attitudes towards Patients' Rights Charters by in-hospital staff (Sbaih, 2002; Raphaely, 2009; Masic & Izetbegovic, 2014;) and patients (Cugnoni, Hormbrey & Miles, 1994; Mastaneh & Mouseli, 2013).

Bruce tackled the ethical conflicts arising in South African hospitals' emergency departments, between a trauma patient's rights and the resuscitation interventions "pragmatically required" (Bruce, 2000:53). Despite the PRC already being in existence at the time of publication, Bruce based her arguments solely on the BOR, and although she makes several salient points, at times she incorrectly attributes rights violations from legitimate emergency care in the presence of informed (or implied) consent.

Concerning decisions that “override patient autonomy”, she correctly states “the most plausible justification for paternalistic interventions should be encapsulated in the principle of beneficence to ensure patient survival, facilitate recovery and limit disability” (Bruce, 2000:54). Unfortunately, her recommendations are unsatisfying because whilst her arguments are formed in the clinical setting, her recommendations are mostly educational reforms aimed at undergraduate programs, thereby leaving the current clinical setting unaddressed.

Limited work has been done on gauging efficacy of the general application of the PRC within the South African hospital system. The conclusions have not been laudable. Nevhutalu laments how “disheartening [it is] to note on a daily basis how generalised patients' rights violations have become… particularly… in public hospitals where the poorest and most vulnerable people in the country seek healthcare services.” (2016:193). One of her recommendations for improved delivery of patients’ rights includes developing “specific rights charters” for niche patient groups or situations, “e.g. women in labour, psychiatric patients” (Nevhutalu, 2016:206).

1.3 Research Question

In this research report, I will answer the question: Should the South African National Patients’ Rights Charter be applied in its entirety to the prehospital emergency medical setting, and if not, which patient rights should the emergency practitioner dedicate time and effort to upholding, and which rights are morally dispensable in favour of providing timely emergency medical care and transport?

1.4 Rationale for Study

In the growing rights-oriented ethos of modern society, it is valuable and necessary to publish those rights in such a way that they are clear to both the claimants (those to whom the rights are ascribed) and the healthcare system workers and policymakers (who are tasked with offering and ensuring those rights). It is obvious that the current PRC tries to describe the rights of the consumers of the national healthcare system in very broad strokes, catering to the entire range of healthcare services and settings.

However, when one considers the national (or even global) healthcare system, it is reasonable to divide it into two overall categories: that of the lesser portion of services provided in an emergency, and that of the greater portion of services provided in the non-emergency. For the most part, the catch-all format of the PRC is suitable and applicable to the greater part of the healthcare system, because the majority of the system is designed to offer its care and services in the non-emergency environment. In this environment, self-identified patients make appointments with healthcare providers (usually within office hours); they can be instructed ahead of time to do (or refrain from doing) certain things in preparation for their consultation and treatment; they make their own way to the healthcare facilities; they wait patiently to be seen; they are conscious and interactive and readily able to give consent to treatment; they are consulted in a setting familiar and suited to the needs of the practitioner; very often a variety of health services are clustered together, making referral, further consultation, and escalation of care possible; and their records can be stored centrally and accessibly. In sum, the non-emergency setting carries an aura of quiet dignity, where time and resources are available to prepare for, and facilitate, the patient through a pathway of management.

Not so the emergency setting. Here, the patients do not recognise themselves as patients until the moment the accident or acute illness strikes. They are not normally in a position to make (or travel to) an appointment but need the emergency system to be able to provide care whenever and wherever the patient finds themselves in need. Invariably, emergency scenes are unpredictable, hostile, potentially dangerous, poorly lit, cramped or exposed, contaminated in numerous ways, crowded with onlookers, and generally unsuitable for a more traditional style of assessment and treatment. Emergency medical complaints are usually time sensitive and are minimally manageable at the scene of the onset/accident. Resources, personnel and expertise are limited, and an emergency medical worker must “make-do” with what she has available, usually needing to fulfil numerous and varied roles simultaneously (e.g. safety officer, clinician, administrator, counsellor, etc.). Often patients are unconscious or in a state where they are unable to provide consent or a verbal medical history for themselves (let alone provide written medical records). Each new emergency thrusts a patient and an emergency healthcare provider together, with little chance of there being any prior patient-practitioner interaction or relationship. In short,

the emergency setting is messy, uncontrolled, constrained in resources and the range of services it can offer, time-critical, and very often, life-threatening or life-changing in nature for the patient.

With this in mind, a review of the Patients' Rights Charter presents difficulties in determining which rights are applicable to the prehospital emergency setting (clearly, some are completely unattainable or not applicable at all) and offers no guidance on how to interpret or apply a patient's rights (in total or in part) on the emergency side of the healthcare system. Thus, I feel that a normative analysis of the PRC through the lens of the medical emergency is warranted and will provide valuable guidance on its ethical interpretation and application in the prehospital emergency clinical environment. To my knowledge, such a normative analysis has not been done before.

1.5 Thesis

In this research report, I will argue that the South African National Patients' Rights Charter is inadequately suited to application within the prehospital emergency medical setting, and that in certain time-critical, life-threatening emergency situations, the emergency practitioner ought to dedicate *some* time and effort to upholding *selected* patient's rights, but is morally justified in dispensing with others, or dealing with them superficially, in favour of providing timely emergency medical care and transport.

1.6 Research Aim

To articulate and defend the theory that the South African National Patients' Rights Charter is inadequately suited to being applied in the prehospital emergency medical setting, and that in certain time-critical, life-threatening emergency situations, the emergency practitioner would be morally justified in dispensing with some of the patient's rights in favour of providing timely emergency medical care and transport.

1.7 Research Objectives

In order to achieve the above aim, I will meet the following objectives:

1. To identify the prescriptive purpose(s) of the PRC and critically evaluate its suitability and efficacy in attaining that/those purpose(s) in general, with particular reference to Rights Theory.

2. To compare, by using the available literature, the prehospital emergency medical environment with the non-emergency in-hospital environment, along with common medical and traumatic conditions encountered, their severity, time-sensitivity and potential for harm. In so doing, I will highlight the key differences between the non-emergency and the emergency clinical environments.

3. To critically evaluate the feasibility of applying the PRC in its entirety in the prehospital emergency setting, in the light of the variable nature and severity of the emergency situations and conditions encountered.

4. To articulate and defend the normative justification of an emergency practitioner in forgoing certain of the patient's rights as listed in the PRC, in favour of providing timely, life-saving emergency medical care and transport, with particular reference to the theory of *Prima Facie* Duty.

1.8 Research Design and Methods

This research report is a pure normative, philosophical study. It entailed library- and internet-based research of current opinion and thought on patients' rights and their applicability in the emergency setting. There was no involvement of research participants and no generation of new empirical data.

Resources of books and articles from the University of Witwatersrand's health library, education library and eJournal databases, online journal search engines like Pubmed and Google Scholar, and South African Government Gazettes and case law through Sabinet.

I used a standard normative/philosophical methodological approach to this research, including: critical analysis of relevant literature; evaluation of existing definitions and

development of new and appropriate definitions where necessary; identification and critique of assumptions, conceptions and theories held or posed by others; considered application of selected moral theories; and development of arguments in support of my thesis and the defence thereof by counter-example. In establishing each of the objectives listed in section 1.6 above, I apply philosophical argumentative strategy.

1.9 Argumentative Strategy

Because Rights falls within the deontological subcategory of prescriptive moral theory, I will analyse the PRC and its application within the prehospital emergency setting from the point of view of two duty-oriented theories: that of Rights Theory, and of *Prima Facie* Duty. I will apply these theories in defence of my normative premises and thesis, as described below.

Premise 1:

The PRC exists to promote the rights and interests of all patients, especially the right of access to healthcare. These rights are important, hard-won, and imply a burden of duty on the second party (the practitioner or state) to protect and fulfil these rights, as per the National Constitution and Rights Theory.

Premise 2:

The Emergency Medical Services (EMS) exist to fulfil the right of access to healthcare in the prehospital emergency medical setting, by resuscitating and stabilising a patient at the scene of an emergency, and transporting them to an appropriate facility for continued, definitive care.

Premise 3:

Some types of emergency scenes and/or medical emergency conditions are time-critical, and by their nature are incompatible with the complete fulfilment of the requirements of the PRC. Other emergencies are not as urgent and allow a more methodical application of the patient's rights as expounded in the PRC.

Premise 4:

Under careful analysis of the circumstances, as proposed under *Prima Facie* Duty theory, it is morally permissible for the prioritisation of one duty over another/others.

Conclusion:

In certain circumstances, it is morally permissible for an emergency practitioner to forego sections of the Patients' Rights Charter in the prehospital emergency setting, in order to facilitate emergency medical treatment and transport for certain categories of serious, time-critical conditions. The circumstances require careful analysis and would include the consideration of the medical conditions contemplated in premise 3, along with a weighing-up of the importance of the conflicting duties inherent in premises 1 and 2.

1.10 Research Outcomes

In this research report, I hope to identify elements of the Patients' Rights Charter that are not applicable, or realisable only with significant time- and resource investments, which may compromise the timeous medical management and transport of the critical prehospital emergency patient. These incompatibilities of the PRC with the prehospital emergency setting are a potential source of confusion and hesitation for the emergency practitioner and may result in the delayed management of the patient, risking both negative medical sequelae for the patient and ethico-legal ramifications for the patient-practitioner relationship.

As such, in an effort to produce a tangible outcome from this research report, I formulate and propose a *Patients' Emergency Rights Charter (PERC)*, in which I tailor the existing PRC rights useful for application in the emergency setting, remove those elements not useful, augment with additional reasonably warranted rights, and create a tiering system to guide a practitioner's application of essential and non-essential rights. I envisage that the *PERC* would be valuable to operational emergency practitioners by firstly removing the clutter from the current PRC and presenting a pared-down guideline; secondly, by framing the rights in immediately applicable ways without requiring an additional layer of interpretation for the prehospital emergency

setting; and lastly, by legitimising the limitation of rights fulfilment in the face of a life-threatening medical emergency.

1.11 Limitations

As the literature review has indicated, there is a paucity of empirical and normative literature concerning the application of patients' rights within the prehospital emergency setting. In many respects, therefore, what follows is as much a contribution to further debate – and hopefully policy development – as an examination of current policies read against practicality.

1.12 Overview of Chapters

An overview of my research report follows:

Chapter 1: Introduction & literature analysis

This has been an overview of the research question and thesis, aims and objectives of my research report, along with a survey of the pertinent literature.

Chapter 2: The South African National Patients' Rights Charter

An examination of the PRC, it's creation, its basis in law and morality, its international equivalents, its aims and functions, and a critique of its efficacy in achieving those aims in general application within the non-emergency healthcare setting, addressing objective 1 and underscoring premise 1.

Chapter 3: The nature of the EMS and emergency medical conditions

A description of the emergency medical services, a comparison of the prehospital emergency setting with the in-hospital setting, a discussion of the types and severities of common medical emergencies encountered and their time-sensitivity, addressing objective 2, and underscoring premises 2 and 3.

Chapter 4: A normative analysis of applying the Patients' Rights Charter in the prehospital emergency setting.

This chapter considers whether the PRC is usable in the prehospital emergency setting, and considers the competing time-related priorities of fulfilling a patient's rights and providing urgent medical treatment and transport. I highlight the shortcomings of Rights Theory in the context of an emergency and argue that the theory of *Prima Facie* Duty would provide greater flexibility and consideration of the circumstances in the prehospital emergency setting, addressing objectives 3 and 4, and underscoring premise 4.

Chapter 5: The *Patients' Emergency Rights Charter*

In this chapter, I draw together the points I have argued throughout the earlier chapters and propose an alternative *Patients' Emergency Rights Charter* (PERC) suitable for application within the prehospital emergency setting, with minimal additional interpretation required.

Chapter 6: Conclusion

A summary of the premises, conclusion and thesis in answer to the research question. A recapitulation of the objectives and a discussion of how the aim has been met through the progression of chapters of the research report.

1.13 Conclusion

In this chapter, I have examined the available literature on patients' rights and their provision and protection in the emergency medical setting. I have stated my research question and proposed my thesis along with its aims and objectives. I have described the research design, research methods and intended outcomes, and have concluded with an overview of the remaining chapters of the research report.

In the next chapter, I will examine and critique the South African National Patients' Rights Charter and its application within the non-emergency, in-hospital, healthcare setting.

CHAPTER 2: The South African National Patients' Rights Charter

2.1 Introduction

In this chapter I intend to identify the prescriptive purpose(s) of the Patients' Rights Charter and critically evaluate its suitability and efficacy in attaining that/those purpose(s) in general, with particular reference to Rights Theory.

I will begin by giving a brief context of the development of the South African National Patients' Rights Charter (PRC), and will highlight a sample of comparative international rights charters. I will then examine its aims and functions, followed by its basis in law and morality with special reference to Rights Theory. Once the ideals of the PRC have been laid out, I will take a closer look at the content of the PRC and critique its efficacy in the "in-hospital" setting[1]. I will then conclude with a summary of the prescriptive purpose(s) of the PRC and my thoughts on its efficacy in achieving that/those purpose(s).

2.2 History and context of the PRC development

There is little in the literature detailing the development of the PRC, other than a few clues in the preamble of the version published by the Health Professions Council of South Africa (HPCSA) as the "Guidelines for good practice in the health care professions, booklet 3" (HPCSA, 2016).

The authorship is claimed by the National Department of Health (NDH) "in consultation with various other bodies" (HPCSA, 2016:1) although their identities are unacknowledged. Work on the Charter would have been commissioned by the then-Minister of Health, Dr Nkosazana Dlamini-Zuma, but it is unclear which Minister

[1] I am aware that one may feel the use of the term "in-hospital" may appear too restrictive, as these medical services may be sought or offered in a variety of facilities such as primary healthcare clinics, mobile clinics, doctors/dentists/physiotherapists/etc. consulting rooms, etc. The point here is that the facility has been purposefully designed to offer a specific medical service and benefits from secondary support services, which, as I will show later, is not the case with the "pre-hospital" setting. I have chosen the term "in-hospital" (or "in hospital") over "in-facility" and am satisfied that it suffices as a catch-all phrase commonly used in the literature.

“launched” the PRC, as she was succeeded in the same year of the Charter’s release (1999) by Dr Manto Tshabalala-Msimang.

In terms of the context of the PRC, by 1999 South Africa was five years into its young democracy and was working hard to right previous wrongs incurred under the apartheid regime. Outrageously unjust healthcare resources had been unevenly distributed along racial lines: by the end of 1981 “[t]he doctor-patient ratio was 1: 330 for White people, 1: 730 for Indian, 1: 12,000 for Coloured and 1: 91,000 for [Black] African[s]” (Seedat, 1984, as cited by Brauns & Stanton, 2016:28). The conditions for both the patient and the healthcare provider must have been unthinkable.

Two important processes in transformation were launched in 1996: The Truth and Reconciliation Commission (TRC) and the National Constitution of the Republic of South Africa (hereafter *the Constitution*) (National Government of South Africa (NGSA), 1996). Heart-breaking in its intensity, the TRC conducted public hearings over the course of the four years, identifying 22,025 victims (TRC, 2002:1), one of them being Bantu Stephen Biko. Counterbalancing this national pain, the Constitution with its lauded second chapter entitled the Bill of Rights (BOR) caused the promise of empowerment to well up within the new Rainbow Nation.

In 1997 the Constitutional Court was tasked to rule on the interpretation of access to healthcare services as named in the BOR (see Soobramoney v Minister of Health, 1997). It seems likely that this case and others served as the impetus for the now-representational NDH to try to encapsulate the rights and responsibilities legislated in various healthcare law, into an easy-to-understand concise document that would mould the expectations of the populace, whilst simultaneously setting the standard for the individual healthcare provider and healthcare institutions. Hence, in 1999, the National Patients’ Rights Charter was launched.

2.3 Equivalent international patients' rights charters

In 1972, the American Hospital Association published their Patients' Bill of Rights containing twelve rights the hospitalised patient could expect. Nine years later the World Medical Association (WMA) promulgated the Declaration of Lisbon which listed six "principal rights which the medical profession seeks to provide to patients" (WMA, 1981).

The 1990s saw a groundswell of patients' rights charters internationally. The World Health Organisation (WHO) published their "Amsterdam Declaration on the Promotion of Patients' Rights in Europe" in 1994 (WHO, 1994), and by 2003, Rider and Mikela showed that charters, bills or laws concerning patients' rights had been issued by seventeen European and Asian countries as well as South Africa and Uruguay (2003:304). In their study, they critically compared six international patients' rights documents and asserted that "South Africa's charter on patients' rights appears to be the most comprehensive of those laws and charters analysed" [2] (Rider & Mikela, 2003:307).

2.4 The aims and functions of the PRC

The aims of the PRC are not explicitly stated, but may be discerned from the introductory paragraph, which reads as follows:

> *"For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore*

[2] It is worth noting though, that the version of the PRC referenced in their article is extracted from a 2001 NDH handbook on primary health care norms and standards, in which it seems the PRC's rights have been expanded upon.

proclaims this PATIENTS' RIGHTS CHARTER as a common standard for achieving the realisation of this right" (NDH, 1999b:1).

The HPCSA booklet version concludes the introduction with: *"Equally, Practitioners should adhere to the stipulations of this charter as it relates to them" (HPCSA, 2008:1).*

Based on the above, I would summarise the intended aims of the Charter as:

1. To ensure the realisation of Section 27(1)(a) of the National Constitution, that "everyone has the right to have access to health care services".
2. To demonstrate the Department of Health's commitment to "uphold, promote and protect" that right.
3. To provide a common standard to guide healthcare providers in the provision of that right.
4. To provide a common standard to healthcare users (patients or clients) against which the realisation of that right may be measured.

It is important to note that patients do not have a right to *health*. This is beyond the power of anyone to ensure. Rather, the BOR and the PRC frame the right in terms of "*access* to health care services". By ensuring this right of access, the State tries to ensure patients within its ambit may enjoy "the highest attainable standard of health" (WHO, 2006:1).

Leading on from the aims, the function of the PRC may be distilled from helpful commentaries published by University of Cape Town's (UCT)'s Department of Public Health (UCT, n.d.) and the non-profit, social justice organisation SECTION27 (2003:118 & 495). I would summarise the PRC function as:

Empowering patients by raising awareness of, and educating them about, the rights they should expect from national health services, in an easy-to-understand format.

At the end of this chapter, I will return to the aims and functions of the PRC, and evaluate if, and how well, they have been achieved by the current version of the Charter.

2.5 The PRC's basis in law

The Patients' Rights Charter is not law. Rather, it is a policy document published by the NDH to educate and guide (as seen above). The poster format of the PRC states: "[t]his Charter is subject to the provisions of any law operating within the Republic of South Africa and to the financial means of the country" (NDH, 1999b:1). Therefore, should any conflict arise between its contents and the law, the PRC would always bow to the law.

That does not mean that a patient cannot use the PRC to hold the NDH accountable. To this end it should act as a trigger to alert a patient that they are due a raft of rights contained in the BOR, the National Health Act (NHA) No. 61 of 2003 (NGSA, 2004) and elsewhere. When harm ensues, gross rights violations may be brought before the courts for civil litigation and would be held against the bedrock of the statues and Constitution upon which the PRC is based. The South African and international legislation underlying the PRC are shown in Table 2.1.

2.6 The PRC's basis in morality

I will now briefly examine the moral theory of Rights in order to classify the rights reflected in the PRC and frame the PRC's relation to morality more clearly. Anything more than a passing examination of Rights is beyond the scope of this report.

The United Nation's International Covenant on Civil and Political Rights (ICCPR) opens with a statement of recognition that "rights derive from the inherent dignity of the human person" (OUNHCHR, 1966: preamble). Effectively, we are endowed with rights solely because we are human.

Wenar (2015:1) defines *rights* as "entitlements (not) to perform certain actions, or (not) to be in certain states; or entitlements that others (not) perform certain actions or (not) be in certain states". For a fuller understanding, it is important to recognise the differences/relations between moral-, human- and legal rights.

2.6.1 Moral, human and legal rights

Moral rights are assertions or entitlements based on the moral justification of what is good or right. This moral justification should be easily recognised by the society in which the right is claimed, and exists without the need of an entity to enforce it or punish its transgression. *Human rights* are a branch of moral rights based on the moral justification that a person possesses an intrinsic dignity which is worthy of respect. That being said, more and more sovereign states are choosing to write human rights into their laws and constitutions, thus making them *legal rights* that are protected by the state. Some argue that human rights are universal, i.e. they just exist in an unwritten form and apply to all people irrespective of any differentiator. However, wherever these rights are unlegislated, transgressions may not be pursued by civil litigation through the local legal mechanisms. Where these legal limitations exist, gross violations of human rights are often brought before international courts concerned with human rights.

There is often much overlap between moral and legal rights, but some rights only fall into one of the categories. That is to say that some moral rights have not been written into law (e.g. the right to an apology) and some lawful rights are immoral (e.g. the former 'Confederate States of America' laws allowing slave ownership).

I will now briefly address the concepts of *claim-rights, power-rights and liberty-rights*, active and passive rights, positive and negative rights, and the three generations of human rights. A thorough discussion of the Hohfeldian incidents (see Nomenclature above) is beyond the scope of this research report, but it is important here to emphasise the role his *claim and power* elements play, as they relate to duties.

2.6.2 Claim-rights

A *claim-right* is a right where the right-holder (the beneficiary of the right) is guaranteed of something through the mandatory action/inaction (the reciprocal duty) of another party (the duty-bearer). Thus, wherever someone has a justifiable claim, there must exist a second party who is obligated to facilitate the realisation of that right, or else the right is imaginary. Nickel asserts that "most if not all human rights are claim rights" (2019:2). An example from the PRC would be the right to confidentiality: a nurse may

have the ability to share my information with others, but because of my right to confidentiality, she has the duty not to.

2.6.3 Power-rights

Wenar (2015:4) explains that a *power-right* is one that alters the rights of others. In the PRC, this is evident in the right to choose a service provider. By choosing Dr A over Dr B, the right-holder (the patient) gives Dr A the right of examining and treating them, whilst simultaneously removing that right from Dr B. Should Dr B have been chosen, Dr A would have no right to treat. Thus, the rights of the doctors are adjusted by the action of the patient's power-right.

2.6.4 Liberty-rights

A *liberty-right* (also known as a *privilege*) exists in the "absence of a duty to abstain from [an] action" (Lazarev, 2005:np). The PRC permits (rather than prohibits) patients to complain about poor service, and thus they have the liberty to do so when the need arises.

2.6.5 Active, passive, positive and negative rights

Rights may also be categorised on whether they are active or passive. Active rights are typically where a person has a right *to something*, whereas passive rights say that a person has a right to be serviced or provided with something *by someone-else*. Wenar states that claim-rights are generally passive (2015:5). For example, the right to health information: the patient must be provided with treatment information by the doctor.

Sounding similar but worthy of distinction are positive and negative rights. Positive rights are those where the right-holder "is entitled to [the] *provision* of some good or service", whilst with a negative right the holder "is entitled to non-interference" (Wenar, 2015:6). In other words, the negative right-holder may not be stopped from doing or having the thing they are entitled to. From the words "provision" and "non-interference" above, it should become clear that both positive and negative rights have a passive beneficiary and are as such, passive rights. An example of a negative right would be

privacy: privacy is the state that continues indefinitely until interfered with. The right is concerned with the state of privacy remaining intact through non-interference.

2.6.6 Human rights' generations

Lastly, human rights are often described as first-, second- or third generation rights. London explains that first generation human rights "were conceived to prevent abuse by limiting state power over individuals" (2011:91). Also known as "civil" or "political rights", they are associated with the value of *freedom*, and include the rights to life, to freedom of speech, to vote, to own property, etc. Second generation rights, or socio-economic rights, are associated with the value of *equality and* "include social or material claims, such as those to housing, water and access to healthcare" (London, 2011:91). Third generation "solidarity rights", are concerned with rights of collectives, and include rights to peace, to self-determination, to humanitarian assistance, etc. (Cornescu, 2009:5-6).

In summary, rights are awarded by society's consensus and are based on the dignity intrinsic to being human. They may be classified in various ways depending on the criterion being examined. The individual rights of the PRC are classified in Table 2.1, as well as being matched to Beauchamp and Childress's (2001) bioethical Principles.

2.7 Overview and structure of the PRC

Comprising approximately 820 words (depending on the version referenced), the PRC can be split into three sections: the introduction (as discussed above), patients' rights, and patients' responsibilities. The patients' rights section contains twelve headings, leading some to erroneously conclude the patient has only twelve rights. The exact number of rights reflected is open to interpretation, but I am able to identify no less than twenty-five individual rights throughout this section.

Rights related to each other in some way are clustered under each heading. The majority of the rights contained in the PRC may be categorised as positive, passive claim-rights, mostly of the second- and third generations, although there are some first-generation rights interspersed. The right-holders are patients (or healthcare consumers) of the national health system and the duty-bearer is either the State

through the NDH, or the treating healthcare provider. The tone of the document captures the intentions to moral rights, but is clearly underwritten by legal, constitutional rights. Some of the PRC's rights are active power-rights and there are two instances of liberty-rights, as evidenced in Table 2.1.

The PRC concludes with the patients' responsibilities section which contains ten duties the patient must fulfil to gain the maximum benefit from the healthcare system. The section is valuable and well conceived.

The original Patients' Rights Charter may be found in Appendix A (NDH, 1999b), and the latest version with a minor revision in the HPCSA's Guidelines on Ethics, booklet 3 (HPCSA, 2016).

What follows below (Table 2.1) is an examination of the PRC, an expansion and categorisation of the rights therein, a cross-reference with the underlying local and international legislation, and a mapping to common bioethical principles.

Patients' Rights (as per PRC headings)	Included Rights (Everyone has the right to…)	Right Classification								Legal basis of Right	Underlying Moral principle(s)			
		Claim	Power	Liberty	Passive	Active	Positive	Negative	Generation		Autonomy	Beneficence	Non-malefic.	Justice
A healthy and safe environment	Healthy environment	✓			✓		✓		3rd	ACHPR art.24: satisfactory environment BOR s24(a): non-harmful environment; s24(b)(i): anti-pollution measures		✓	✓	
	Safe environment	✓			✓		✓		2nd	UDR art.3: security of person BOR s12(1)(c): violence-free; s12(1)(e): treatment not cruel, inhumane or degrading		✓	✓	
Participation in decision-making	Participation in policy development			✓		✓			1st	UDR art21(1) & ACHPR art.13(1): participate in government	✓	✓		✓
	Participation in decision-making on own health matters		✓			✓			1st	ICCPR art.1: self-determination BOR s10: dignity & s12: freedom & security, control over own body NHA s8: participation in decisions	✓	✓		
Access to healthcare	Timely emergency care	✓			✓		✓		2nd	ICESCR art.12(1) & (2)(d) & ACHPR art.16(1) & (2): best attainable health & provision of healthcare BOR s27(3): no refusal of emergency care NHA s5: emergency care	✓	✓	✓	✓
	Informed treatment & rehabilitation	✓			✓		✓		2nd	ICESCR art.12(1) & (2)(d) & ACHPR art.16(1) & (2): best attainable health & provision of healthcare NHA s6(1): full knowledge CA s13(1): health information	✓	✓		✓
	Provision for special needs patients	✓			✓		✓		2nd	ICESCR art10(3) & ACHPR art.18(4): special measures of protection required	✓	✓	✓	✓
	Counselling	✓			✓		✓		2nd	ACHPR art.16(1): best attainable mental health	✓	✓		✓
	Palliative care	✓			✓		✓		2nd	ICESCR art.12(1) & (2)(d) & ACHPR art.16(1) & (2): best attainable health & provision of healthcare	✓	✓	✓	✓
	Be treated with dignity (positive disposition by HCPs)	✓			✓		✓		1st	UDR art.1: dignity & respectful action ACHPR art.5: respect of dignity		✓		
	Full health information, understandable to the patient	✓			✓		✓		2nd	ACHPR art.9(1): receive information NHA s6: full knowledge in understandable language; s10: discharge reports HPA s27A(d): provide information	✓	✓		✓

Table 2.1: Analysis of the PRC (continued overleaf with key)

Patients' Rights (as per PRC headings)	Included Rights (Everyone has the right to…)	Right Classification								Legal basis of Right	Underlying Moral principle(s)			
		Claim	Power	Liberty	Passive	Active	Positive	Negative	Generation		Autonomy	Beneficence	Non-malefic.	Justice
Knowledge of one's health insurance / medical aid scheme	Access to information	✓			✓		✓		2nd	ACHPR art.9(1): receive information BOR s32: access to information PAIA s11 & s50: access to records MSA s29(j): settlement of complaint CPA s70: dispute resolution	✓	✓		
	Challenge decisions			✓		✓			2nd		✓		✓	✓
Choice of healthcare services	Choose healthcare facility and/or practitioner		✓			✓			1st	ICCPR art.1: self-determination NHA s8: participation in decisions. HPA s11: impeding a patient	✓	✓		
Be treated by a named healthcare provider	Clearly identified HCP	✓			✓		✓		3rd	**HPCSA ethics booklet 2(3.1.3.8): name of HCP		✓		
Confidentiality and privacy	Personal information only disclosed with consent	✓			✓		✓		2nd	NHA s14: confidentiality & s15-17: health records PAIA s11 & s50: access to records POPIA total HPA s13: professional confidentiality	✓	✓	✓	
	Non-interference of personal privacy*	✓			✓			✓	1st	UDR art.12 & ICCPR art.17: non-interference of privacy BOR s14: privacy		✓	✓	
Informed consent	Information to make informed decisions	✓			✓		✓		2nd	ICCPR art.1: self-determination; art.7: consent for med. experimentation. ACHPR art.9(1): receive information. NHA s6: full knowledge in understandable language; s7: consent, s8: participation in decisions	✓	✓	✓	✓
	Give consent* with understanding		✓			✓			2nd		✓	✓	✓	✓
Refusal of treatment	Withhold or withdraw* consent at any time*		✓			✓			2nd	ICESCR art.1 & ICCPR art.1: self-determination NHA s6(1)(d): right to refuse	✓	✓	✓	
	Non-interference of bodily security*	✓			✓			✓	1st	UDR art.3 & ACHPR art.4: security/ integrity of person; NHA s7: no treatment without consent		✓	✓	

Table 2.1: Analysis of the PRC (continued overleaf with key)

Patients' Rights (as per PRC headings)	Included Rights (Everyone has the right to…)	Right Classification								Legal basis of Right	Underlying Moral principle(s)			
		Claim	Power	Liberty	Passive	Active	Positive	Negative	Generation		Autonomy	Beneficence	Non-malefic.	Justice
Be referred for a second opinion	Request referral to second HCP	✓			✓		✓		2nd	HPA s11: impeding a patient	✓	✓		
Continuity of care	Not to be abandoned by HCP	✓			✓		✓		2nd	RSA & International case law **HPCSA ethics booklet 1(5.7.1): referral		✓	✓	✓
	Appropriate hand-over of care to another HCP*	✓			✓		✓		2nd			✓	✓	✓
Complaint about health services	Complain			✓		✓			2nd	NHA s18: laying of complaints	✓		✓	
	Receive a response following investigation	✓			✓		✓		2nd		✓		✓	

Table 2.1: Analysis of the Patients' Rights Charter

Key: ACHPR – African Charter for Human and People's Rights 1981; BOR – South African Bill of Rights 1996; CA – Children's Act 2005; CPA – Consumer Protection Act 2008; HCP – Healthcare Provider; HPA - Health Professions Act 1974; HPCSA – Health Professions Council of South Africa; ICCPR – UN International Covenant on Civil and Political Rights 1966; ICESCR – UN International Covenant on Economic, Social and Cultural Rights 1966; MSA – Medical Schemes Act 1998; NHA – National Health Act 2003; PAIA – Promotion of Access to Information Act 2000; POPIA – Protection of Personal Information Act 2014; RSA – Republic of South Africa; UDR – United Nations Universal Declaration of Human Rights 1948.

*Rights inferred but not explicitly stated **Profession's conduct document (i.e. not law).

2.8 Application of the PRC

Some trends become evident when assessing whether the PRC was written to be applied in a universal manner (in all settings) or if it is biased to one type of setting (i.e. in-hospital). These trends include:

- Infrastructure: several rights rely on a pre-existing infrastructure, for example "a healthy and safe environment" needing "adequate water supply, sanitation and waste disposal"; provisions for diverse "special needs" patients; "counselling" facilities. While the elements of these concepts may be universalisable to most healthcare settings, the wording is clearly aimed at the institutionalised in-hospital setting.
- Time to think: numerous rights are only attainable in conducive environments where time pressures are limited. Rights like "provision of full information", "participation in decision-making", "counselling" and "referral" all require in-depth conversations between patients and healthcare providers, sometimes over days or weeks. Decision-making often requires reflection and the input of friends or family who are not necessarily present at the time. Some patients may want to make additional enquiries or research. This all relies on time being available, and on a setting that is quiet and calm. Modern healthcare institutions design their facilities and services around these concepts, but time and peace are not necessarily endemic to all healthcare settings (especially not the prehospital emergency setting).
- Choice: rights that reference *choice* assume that there are always options available. This is generally true in the in-hospital setting. Rights like the "choice of health [service provider]" and "referral for a second opinion" assume that there is more than one service provider to obtain first and second opinions from. In some settings, as in pre-hospital, there are frequently no alternative options available to the patient, other than the one ambulance that arrives.
- Emergency care: only mentioned once, emergency care is framed in the setting of a "health care facility". It is admirable that it should be timely and not dependent on the patient's ability to pay, factors which are equally applicable

to out-of-facility emergency care, but there is a stark absence of any other specifics applicable to or in the prehospital environment.

From the above, it is apparent that the PRC was written with the in-hospital (i.e. in-facility) setting in mind. Indeed this is to be expected, as this is undoubtedly where the bulk of health care is provided. It does however produce a disconnect between the application of the PRC in the in-hospital setting (to which it is suited) and the pre-hospital emergency setting (to which I am arguing it is not suited). Some may think of this disconnect as lee-way, others may think of it, as I do, as a threat to both patient and emergency practitioner.

2.9 General concerns

There are some serious flaws in the current PRC which may cause confusion and over-/under-expectations within the reader, irrespective of the setting it is applied in. I will attempt to briefly describe these below.

The incongruity between some of the headings and their supporting paragraphs is a concern. In some cases, the concept contained within the heading is at odds with, or entirely omitted from, the paragraph it heads. For example, the sections headed “informed consent” and “privacy” never actually include those concepts in the supposed explanation of the right. These are weighty omissions.

In some cases, it seems that the heading is a right to be assumed, but that secondary rights garner all of the explanation (e.g. “confidentiality” is named, but the paragraph does not describe it, only focussing on instances when it may be breached). This section also suffers from a grammatical ambiguity in that whilst the majority of the Charter follows a format “Everyone has the right to…”, this point breaks from the convention and makes it seem as if the information (and not the patient) is the beneficiary of the right.

Some points are excessively legalistic (e.g. “choice of health services”) and seems self-defeating in their attempt to state and clarify the right.

The PRC also includes terms or concepts which are confusing, e.g. “counselling… without violence”, and the right to “know” the healthcare provider. The implications of

the former are horrifying, and of the latter, mystifying, i.e. to what extent is the healthcare provider expected to let herself be "known" by a patient?

In one case, the PRC limits the right's duty to the first "health care professional" who took initial responsibility, but to none of the subsequent ones (see "continuity of care"). In the same point, the undergirding concepts of *referral* and *hand-over* are not touched upon at all[3].

At a more technical level, there are several instances where the PRC incorrectly uses the term "right(s)" when it means "liberty" or "power" as conceived by Hohfeld (UKEssays, 2018). Thus, the patient does not have a *right* to participate in policy-making, complain or challenge decisions, but rather they are at *liberty* to do so should they wish and, as is the nature of a Hohfeldian liberty, they may not be interfered with when they do. Similarly, the patient does not have a mere passive right to participate in decision-making, choose a healthcare provider, or give or withhold consent. Rather they have the power to do the above, and as such may actively permit, prevent or limit the actions of others over whom they hold this power-right.

The PRC is unclear on matters of recourse and provides no guidance on how a patient may obtain relief should they feel their rights have been denied. Flood and May (2012) assert that any patients' rights charter without an ombudsman or commissioner who can receive and resolve patients' complaints, is in effect "a toothless tiger" (p1583). The office of Health Ombud has recently been created in South Africa, and so future versions of the PRC should include these details for complaint escalation.

Lastly, as mentioned in earlier sections, the PRC is grounded in law but is itself not law. The underlying intentions are clearly moral in nature, but the terminology is legal. This causes problems for general interpretation of the PRC, problems which are amplified when trying to apply the PRC in the prehospital environment. For example,

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[3] In the HPCSA's 2016 revision of the PRC, the single material change was the addition of the clause "without appropriate referral or hand-over" (HPCSA, 2016:3). However, as of October 2020, other organisations like the South African Medical Association (SAMA), SA Federation for Mental Health (SAFMH), Ideal Clinic SA and Netcare Hospital Group still have the original unrevised version on their websites.

it is both a moral and legal duty of a healthcare organisation to ensure that their hospital is both safe and healthy for their patients, staff and visitors. However, whilst it may be a moral duty for a paramedic to attempt to make the prehospital scene of an accident as safe as possible, it is impossible to hold the same paramedic legally liable if they are unable to do so despite their every effort. Some scenes need very specialised services to make them safe (i.e. electrical services, hazardous materials specialists, swift-water rescue, etc.) and patients often sustain additional harm (or even die) whilst awaiting the arrival of these specialists. The same is true for cases of referral and protection of privacy: these are obviously the morally right course of action, but if it is not possible due to lack of resources or the exposed site of the emergency, then there cannot be legal lability held against the paramedic should the rights be unmet. Thus, in its generalisations it seems to blur moral rights with legal rights, aspiring to ideals that would be the case in the 'best of all possible worlds' (as Voltaire snidely quotes Leibniz). This conflation causes confusion and undermines the purpose of the Charter to clarify, inform and guide.

In ending these two sections above, the question must be asked: How should the PRC be applied? My answer: *in good faith*. It is clearly well-intentioned and important, but it is incomplete and unclear on several points. The right- and duty-bearers are often expected to fill in blanks with as much good faith as possible, but the risk exists for both parties to potentially misalign their expectations of services sought or offered, and this opens the pathway for grievances to occur. It is also clearly biased towards the in-hospital clinical setting. The above thus embodies the intrinsic weaknesses and dangers of applying the PRC in general.

2.10 A return to the PRC's aims and function

I believe the PRC does fulfil its aims and function to a degree, but it is unnecessarily convoluted. The overall structure of the document could have been better planned: rights could have been ordered in relation to their field of influence (those being claimed most-often by the greatest number of patients). Certain points are worded poorly, often expecting the reader to link a heading with a partially related explanatory paragraph to arrive at a fully-fledged understanding of a right (e.g. "confidentiality &

privacy"). In some cases, important concepts have been left out entirely (e.g. the description of consent, the concept of referral in continuity of care, etc.).

It is not my intension to undercut the value of the PRC. On the contrary, I believe it is a very valuable tool in the progress of healthcare within South Africa. However, as is the nature of progress, the tool must be sharpened to fit the times, and I would suggest that the South African Patients' Rights Charter is due for a revision.

2.11 Premise

From the discussion above I have affirmed the PRC role in protecting the rights and interests of all patients, especially the right of access to healthcare. These rights are important, hard-won, and imply a burden of duty on the second party (the practitioner or state) to promote, protect and fulfil these rights, both legally as per the National Constitution, and morally as per Rights Theory.

2.12 Conclusion

In this chapter, I have given a historical context of the development of the South African National Patients' Rights Charter both domestically and internationally. I have examined the aims and functions of the PRC and shown its basis in law and morality with special reference to Rights Theory. I examined the contents of the PRC and critiqued its efficacy in achieving those ideals in the South African healthcare setting.

In the next chapter, I turn my attention to the nature of prehospital medical emergencies and the institutions and professionals that cater to this niche: the Emergency Medical Services (EMS).

CHAPTER 3: The nature of Emergency Medical Services and emergency medical conditions

3.1 Introduction

In this chapter I will give a brief description of the South African Emergency Medical Services (EMS) and its aims. I will then describe the conditions of an average prehospital emergency and make a passing comparison to the conditions found in in-hospital practice. Thereafter, I will examine the types and severities of common medical emergencies encountered, their time-sensitivity and potential for harm. I will end the chapter with strategies a paramedic may use to guide their clinical triage of a patient.

3.2 Pertinent definitions

It would be reasonable at this point to define the terms which will be frequently used in this chapter. Note the common themes of *urgency* and *harm*.

The Medical Schemes Act (Act No. 131 of 1998, as amended) regulations define an "emergency medical condition" as a "sudden and, at the 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*" (NDH, 1999a:s7, italics mine).

Kramer offers a rambling definition of emergency medical treatment which concludes with: "*urgent* attention and appropriate medical intervention in medical conditions in which time is critical to *prevent deterioration*" (Kramer, 2008:55, italics mine).

Moore defines an emergency medical service as "a comprehensive [civilian] system which provides the arrangements of personnel, facilities and equipment for the effective, coordinated and *timely* delivery of health, … safety [and transportation] services to *victims of sudden illness or injury*" (Moore, 1999:325, parenthetic augmentation mine, italics mine).

These themes of urgency and harm will continue to reappear throughout this research report and are important for the understanding of my normative argument in sections to follow. The Cambridge dictionary defines *urgency* as “the quality of being very important and needing attention immediately”, and *harm* as “to damage something or make something worse” (Cambridge Advanced Learner's Dictionary, 2021).

3.3 A brief description of the South African EMS

Since their introduction in the Napoleonic wars (Skandalakis *et al.*, 2006), the chief benefit ambulances provide is minimising the time between the onset of a sudden medical emergency and its resolution. This is due to systems which allow rapid arrival at a patient’s side (dispatch centres, emergency vehicles, relevant laws, etc.); early medical interventions to resuscitate and stabilise the patient; and rapid transportation of the patient to the hospital setting where specialised, definitive care may be instituted.

I would summarise the primary aims of an EMS system as:

1. The early access to patients experiencing an acute injury or illness;
2. Rapid and effective on-scene treatment aimed at achieving a temporised (or more durable) physiological stabilisation; and
3. Safe and rapid transportation of the patient to the nearest appropriate medical facility.

Other aims may be included like public education, health and safety functions, primary health and public health functions, amongst others.

The South African EMS developed at pace with European and American services. Ambulances initially provided no form of medical care. They were merely a means of transporting patients to hospital, staffed by a solitary driver who would rely “on the goodwill of the public to help him load the patient and [would] subsequently rush… off to hospital without being able to provide any [care]” (Dalbock, 1996:118). However, with medical progress, it was recognised that initial actions could be performed on the scene or during transport which improved a patient’s outcome, and so a trained paramedic was added and became responsible for patient care *en route.* Early interventions like cardiopulmonary resuscitation, defibrillation, haemorrhage control

and others, along with rapid transport, were shown to positively improve patients' survival (Cummins *et al.*, 1985; Morrison *et al.*, 2000; Garot, 2007; Yasuyuki, 2012; Clark, Winchell & Betensky, 2013).

South Africa implemented the "Anglo-American model" of EMS (Al-Shaqsi, 2010). Treatment is provided by paramedics (as opposed to doctors under the "European model") capable of providing basic to advanced levels of life support. The model emphasises short on-scene times for critical patients: only directly life-saving interventions should be performed before leaving for the hospital, spending no more than 10 minutes on scene, which translates to earlier surgical intervention leading to improved survival (Campbell & Alson, 2016:40).

The Health Professions Council of South Africa (HPCSA) instituted the Profession Board for Emergency Care Personnel (PBECP) which curates a national EMS protocol. This document defines the medical scopes of practice at each level of certification and much progress has been made in formalising the profession in the last 20 years (Vincent-Lambert, 2015). A sample of EMS qualifications available historically and currently is shown in Table 3.1.

The services themselves are comprised of provincial, private and voluntary entities, governed by a raft of national and provincial regulations (Van Hussteen, 2016). Vehicles and equipment range widely, from the bare legal minimum to cutting edge purpose-built devices. Services are clustered around cities; rural areas suffer from prolonged response times (MacFarlane, van Loggerenberg & Kloeck, 2005).

In summary, the South African EMS is markedly heterogenous, with public and private stakeholders and clients, and is, like healthcare entities globally, trying to evolve as it seeks to balance requirements with resources. In the next section I will look at the pre-hospital emergency setting and consider how it compares with the in-hospital environment.

Qualification	NQF Level	Entry requirements	Course Duration	Life Support Level	Sample of Skills	Registered practitioners*
Basic Ambulance Assistant (BAA)	None (HPCSA register closed 2017)	Matriculant	4-6 weeks, full time, offered by HPCSA-accredited training centre	Basic (BLS), supervised practice	CPR, oxygen administration, suctioning, splinting, bandaging, childbirth	149,163 (representing the largest single register of the HPCSA)
Ambulance Emergency Assistant (AEA)	None (HPCSA register closed 2017)	Registered BAA	3 months, full time, offered by HPCSA-accredited training centre	Intermediate (ILS)	BLS skills as well as defibrillation, intravenous cannulation, some IV medications, breech childbirth, neonatal resuscitation	18,466
Critical Care Assistant (CCA)	None (HPCSA register closing Dec. 2020)	Registered AEA	11 months, full time, offered by HPCSA-accredited training centre	Advanced (ALS)	ILS skills as well as advanced airway management (low risk), 12-lead ECG analysis, arrythmia management, emergency IV drugs, ICU equipment usage	Combined register, numbers uncertain due to duplication, less than 2,400
National Diploma in Emergency Medical Care (N.Dip:EMC)	NQF 06	Matriculant	2 years, full time, offered by DoHET-accredited tertiary education institution	Advanced (ALS)	Most CCA skills and others. Some high-risk skills require approval by a an ECP	
Bachelor of Emergency Medical Care (BEMC) or Bachelor of Technology in Emergency Medical Care (B.Tech: EMC)	NQF 08	Matriculant	4 years, full time, offered by DoHET-accredited tertiary education institution. Includes thousands of hours of facilitated experiential practice.	Advanced (ALS)	ALS skills including all emergency IV drugs, advanced airway management, select emergency surgical interventions, ICU equipment usage, diagnostics, advanced medical rescue	882

Table 3.1: Sample of South African EMS qualifications

Key: ALS – Advanced Life Support; BLS – Basic Life Support; CPR – Cardiopulmonary resuscitation; DoHET – Department of Higher Education and Training; ECP – Emergency Care Practitioner (Bachelor's register at HPCSA); HPCSA – Health Professions Council of South Africa; ICU – Intensive Care Unit; ILS – Intermediate Life Support; IV – Intravenous; NQF – National Qualifications Framework. * HPCSA IRegister numbers as of 21st March 2021.

3.4 The pre-hospital emergency setting

The South African pre-hospital emergency environment is dynamic and uncontrollable, with significant factors that have physical and psychological effects on EMS practitioners, complicating their work in providing emergency care and transport. These factors, which are for the most part absent from the in-hospital environment, may be thought of as unique stressors or complicators for the emergency medical practitioner. Here I will depend mostly on my own experiences as an operational ALS paramedic, but articles in the press give accounts of a day in the life of a South African paramedic (see EmergencyLive, 2016; Sunday Tribune, 2018; Deutsche Presse-Agentur, 2018; and others).

Factors include emergency response driving (also known as “responding”); medical equipment movement; patient- access, extrication and movement; on-scene hazards and environmental- and human conditions; inter-service interactions; control centre communications; resource- and personnel limitations; care during transport; physiological stressors; and non-criteria case dispatches. A summary comparing these unique factors in the prehospital environment to the in-hospital environment may be seen in Table 3.2 below.

In earlier research, I showed that ALS providers were leaving operational practice for a variety of reasons, many of which had to do with organisational issues: poor remuneration, a sense of limited control over their situation, a lack of appreciation, and feeling overworked (Hackland & Stein, 2011). Govender *et al*. (2012) corroborated that such factors were significant in causing ALS to choose to seek employment overseas, and Stassen *et al*. says “paramedics feel overworked, undervalued, poorly remunerated and unsupported by their superiors” (2013:331).

Additionally, studies have shown that EMS personnel struggle with unhealthy lifestyle behaviours (Gresse *et al.*, 2020) and chronic fatigue (Patterson *et al.*, 2010; 2012) due to constant disruption to their sleep cycles. This reduces performance and concentration, and has a potentially disastrous effects when considering high-focus tasks such as emergency driving and critical medical procedures.

In this section I have attempted to show the unique environment that EMS practitioners provide life-saving treatment in, very often at risk to themselves. I have demonstrated how it is uncontrolled, difficult, uncomfortable and dangerous. In the next sections, I will address the types of patients encountered and the complex conditions they may present with.

3.5 Commonly encountered patients

Pre-hospital emergency patients vary widely. On any given day a paramedic may be required to administer emergency care to all of the following patients: adults in various states of (poor) health; geriatrics with aging physiology; pregnant women with(out) complications and at any stage of labour; adolescents; children; infants; newborns; and micro-premature neonates as tiny as 500 grams. Any of them may have concomitant or pre-existing conditions, and any of them may suffer illness or injury at any time of the day or night.

This diversity of patients greatly complicates the provision of emergency medical care in the prehospital setting, but EMS service providers and practitioners must be able to manage issues of diversity, and the challenges that this diversity presents.

Condition / Factor / Stressor	Pre-hospital Setting	In-hospital Setting
Emergency response driving Driving with emergency lights and sirens, high speeds, crossing intersections against red lights, lane splitting, etc.	Every priority 1 dispatch, often hundreds of kilometres per shift. Real risk of accident endangering life & limb; Risk to other drivers and pedestrians. Visibility poor, road surfaces wet or unstable, roadside animals, etc.	Not applicable. Patients present themselves to the ward/clinic, etc.
Medical equipment movement All stock & equipment for every size patient, medications, oxygen cylinder(s), defibrillator, suction unit, splints, spinal immobilisation patient movement equipment, etc.	Paramedic must carry whatever they might need. Physically demanding with risk of injury. Any additional stock/equipment would require an additional trip back to the ambulance, or the dispatch of a second crew.	Not applicable. All equipment and stock housed in cabinets in treatment area. Additional resources available from within facility. Porter staff act as runners.
Patient access Patients in unmarked locations; poor directions; locked behind doors; entrapped in vehicle wreckage, inside collapsed buildings or stuck in industrial machinery.	May take minutes to hours to locate and access patient. May involve off-road driving, hiking or swimming. Occasionally rope, ladder or boat access required. Specialised services may be required for access.	Not applicable. Patients present themselves to the facility.
On-scene physical hazards Numerous and diverse, ranging from minimal to life-threatening; in addition to infectious risk.	The Paramedic must identify and mitigate all hazards before and during patient care. Additional specialised services may be required to attend scene.	Mainly infectious risk. Aggressive patients are managed by hospital security.
On-scene environmental conditions Treatment space, lighting, temperature, ventilation, etc.	Uncontrolled environmental factors: often cramped, hot/cold, exposed to sun & weather, poor lighting, loud/constant noise, fumes, etc.	Wards and units are designed for patient care. Indoor environment, controlled and comfortable.
On-scene human conditions Patients and bystanders may be inebriated, psychotic, violent or uncooperative. Mobs are excitable and unpredictable. Armed criminal activity common in South Africa.	Variable, unpredictable, with a risk of extreme violence. Paramedics have little backup if Police services are not on scene. Several recent instances of EMS staff assaulted and occasionally being killed (see Sowetan Live, 2018).	Similar patient variables exist. However, hospital security available to manage unruly patients and control groups; additional personnel immediately available; criminal suspects will have a police escort.
Inter-service interactions Specialised services required to work together. Often conflicting priorities and methods.	Forced inter-agency cooperation, often leading to conflict. Team assembled at time and site of emergency, no preparation. No cross-service jurisdiction.	Similar inter-personal issues. However, staff more familiar with each other and more commonly work together; inter-departmental planning possible; conflict can be resolved through management structures.

Table 3.2: Comparison of pre-hospital and in-hospital settings (continued overleaf)

Condition / Factor / Stressor	Pre-hospital Setting	In-hospital Setting
Control centre communications EMS controllers need information to allocate additional resources, pre-notify hospitals, activate helicopters, etc.	Necessary and important flow of information via radio or cellular telephone; risks interfering with medical care.	Not applicable. Most units have an administrator capable of passing information to/from relevant stakeholders.
Limited resources & personnel Often only 1 ambulance with 2 crew allocated to a scene. Scene conditions may require more resources than are available.	Many tasks to be performed by limited numbers of staff. Limited equipment and stock. Additional units/staff may not be available, or significant delays incurred awaiting their arrival to scene.	Depending on the type and level of hospital additional staff and high-level expertise available at short notice. Significant amount of stock and equipment.
Patient extrication and movement Patients must be safely released from car wreckage, rock falls, etc. Must be moved through narrow spaces, up/down stairwells, etc.	Technical, time- and resource-consuming. Often dangerous. Often involves lifting, twisting and carrying. Risk of joint and spinal injuries for the rescuer.	Extrication not applicable. Patient moving devices available (*Patslide*®, hoists, etc.). Additional personnel available; a dedicated porter department available.
Care during transport Patients may require ongoing medical procedures en route hospital. Emergency response driving may be required for critical patients.	Confined ambulance compartment; frequent speed & direction changes complicate patient management; fall risk to staff; joint sprains common. Risk of being struck by moving equipment.	Short patient transfers between departments. Risks not applicable.
Non-criteria case dispatches Non-emergency (colds & flu, early labour, etc.) & false (prank) calls. Often a failure of call-taking triage or dispatch policy.	Moral obligation on EMS services to attend to each call for help. Places staff at unnecessary risk from response driving; ties up resources from real emergencies.	Low acuity, non-urgent patients which triage protocols can recognise as low priority, ensuring resources available for higher priority cases. Occasional malingering patient feigning illness
Physiological stressors E.g.: Fatigue, motion changes, vibration, temperature changes, hunger, dehydration, strenuous exertion with risk of injury, etc.	Shift work sleep disturbance	Similar
	Environmental changes	Not a factor
	No time for rest/bodily functions	Mandatory rest & meal breaks
	Strenuous exertion, constant risk of injury.	Limited due to resources and health & safety policies.
Psychological stressors	Cumulative effect of above stressors; Exposure to violent crime and its effects; Daily risk of injury and death.	Limited psychological factors of this nature. Others may apply.

Table 3.2: Comparison of pre-hospital and in-hospital settings

3.6 Emergency medical conditions

3.6.1 Types of emergency medical conditions

Broadly speaking, emergency conditions may be spilt into two main categories:

- Medical aetiology: resulting from some pathological process happening inside the patient's body. Medical emergencies often involve the acute exacerbation or progression of a disease that causes the malfunction of an organ or organ system.
- Traumatic aetiology: resulting from the application of force or other energy source (e.g. electrical, thermal, chemical reactants, etc.) to the body or part thereof, which causes damage to a tissue, organ or organ system. These force-related injuries vary depending on the magnitude of the force applied and the surface area over which the force was applied. Variables produce specific types of injuries, classically "blunt" or "penetrating" trauma.

In both aetiologies, the failure of an organ (system) has a detrimental effect on the next organ (system). Most important of these systems are the neurological system, the respiratory system and the cardiovascular (or circulatory) system (CVS). The three central systems are tied together closely to maintain the metabolic demands (i.e. homeostasis) of the human organism.

Various insults to the respiratory or circulatory systems may adversely effect oxygen delivery to the brain, which is recognised to be the organ most sensitive to oxygen deprivation, incurring irreversible damage within minutes (Sekhon, Ainslie & Griesdale, 2017). Each progressive minute that passes without restoring oxygen delivery increases the brain damage incurred and risks the dysfunction of critical control centres within the brainstem, chiefly the respiratory control centre and the cardiac and vasomotor control centres. Damage to these centres may cause respiratory failure (leading to respiratory arrest) and/or circulatory shock. This positive feedback loop causes additional, increasing neurological damage. Cardiac arrest will develop if these derangements are left unchecked.

Similarly, conditions involving a closed (or closing) airway, difficulty breathing, severe bleeding, cardiac arrhythmias, direct brain trauma, spinal cord transection and the like can lead to respiratory insufficiency, irreversible shock, and the eventual death of the patient. Numerous studies have shown the importance of **minimising the time to definitive treatment** for life-threatening conditions, starting with temporising management on scene if possible (Heckbert *et al.*, 1998; Huber *et al.*, 2005; Kauvar, Lefering & Wade, 2006; Bernard *et al.*, 2010; Postma *et al.*, 2011; Oteir *et al.*, 2014).

EMS providers must therefore correct the failure of each organ system as best as possible and prevent any worsening of the injuries already incurred, whilst extricating the patient to hospital in as little time as possible, thereby facilitating the earliest possible surgical or specialist intervention.

A short list of examples of critical life-threatening conditions which require immediate treatment is shown below in Table 3.3. This list is by no means exhaustive.

Examples of critical conditions and injuries requiring immediate treatment
Respiratory arrest
Cardiopulmonary arrest
Major head trauma with hypoventilation
Active seizures
Unresponsiveness
Respiratory failure • Hypoventilation • Cyanosis • Bradycardia (impending cardiopulmonary arrest)
Shock/sepsis with signs of hypoperfusion
Anaphylactic reaction • Respiratory compromise (dyspnoea, wheeze, stridor, hypoxemia) • Reduced systolic blood pressure

Table 3.3: Examples of critical conditions and injuries requiring immediate treatment
(Source: ENA Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4 Implementation Handbook 2020 Ed. Pg43. Extracts, used with permission)

3.6.2 Severity of emergency medical conditions

In addition to classification based on *type*, emergency conditions may also be classified based on their *severity*. A certain type of acute medical condition may be minor, moderate or severe. Consider an exacerbation of asthma: a mild instance may cause some chest tightness but resolve within minutes of the patient's prescribed medications. In this case, the EMS may not even be activated. A moderate asthma attack may last longer, cause worsened breathing, or incite more distress for the patient than a minor attack normally would. The patient may be anxious, but if vital signs are acceptable, EMS management would be conservative and include non-emergency transport to hospital for further assessment and treatment. However, a severe asthma attack may present with a semi-conscious patient at the limit of his respiratory ability, barely moving any air into/out of his lungs, with circulatory and neurological malfunction evident. This patient is peri-arrest (i.e. in danger of imminent death) and requires immediate, maximal intervention on scene to improve ventilation and oxygenation, and prevent respiratory and cardiac arrest. The condition would require minimal on-scene time in favour of rapid transport (with lights and sirens) to a pre-alerted emergency department with specialist capabilities. Any delay in treatment or transport may result in death.

Generally speaking, as the severity of a condition increases, so does its potential to adversely affect mortality and morbidity. Severe cases hold the greatest potential for organ damage leading to death if not managed promptly. Moderate severity conditions may worsen into severe, and severe conditions that respond to treatment may recede to moderate. See Table 3.4 for examples of medical and traumatic emergency conditions that present at different severities.

	Medical aetiology	Trauma aetiology
Minor	**Asthma:** quiet wheezing, calm patient **Allergy:** localised itching skin **Consciousness:** fainting, now awake **Heart failure:** swollen ankles	**Burns:** small surface area, shallow **Bleeding:** capillary, surface **Heat injury:** cramps **Extremity injuries:** single, closed, small bone fractures
Moderate	**Asthma:** diffuse wheezing **Allergy:** Anaphylaxis with diffuse rash, anxiety **Consciousness:** drowsy but rousable **Seizure:** single, short **Heart failure:** basal pulmonary oedema, adequate oxygenation	**Burns:** larger surface area, partial thickness **Bleeding:** venous, controllable **Heat injury:** exhaustion **Extremity injuries:** long bone fractures, large joint dislocations, perfusion intact **Electrocution** without cardiac/respiratory deficit
Severe	**Asthma:** Silent chest, unable to speak, hypoxia **Allergy:** Anaphylaxis with shock or airway closure **Consciousness:** Unconscious, unrousable **Seizure:** prolonged, multiple **Heart failure:** shock, significant pulmonary oedema, hypoxia **Myocardial infarction*** **Stroke*** **Cardiac arrest*** from any cause	**Burns:** extensive surface area, full thickness **Bleeding:** arterial, internal or massive external haemorrhage **Heat injury:** heat stroke, seizures **Extremity injuries:** bilateral femur fractures, compound fractures with bleeding, distal perfusion effected **Electrocution** with cardiac/respiratory deficit or cardiac arrest **Penetrating injuries*:** head, neck, torso, pelvis, proximal limbs **Blunt force injuries*:** head, neck, torso, pelvis **High spinal cord transection***

Table 3.4: Examples of emergency conditions with increasing severity or *maximal severity from outset

3.6.3 Severity triaging tools

Recognising the severity of an emergency condition relies heavily on the clinical judgement of paramedic, but several tools have been developed to assist the practitioner. For trauma aetiology, the International Trauma Life Support (ITLS)'s Rapid Trauma Survey (RTS) is designed for swift use in the prehospital setting and aims to identify life-threatening conditions and decide on transport options in less than two minutes (Campbell & Alson, 2016). The Centers for Disease Control and Prevention (CDC) issued their "Guidelines for Field Triage of Injured Patients" (Sasser *et al.*, 2012), to detect the most severely injured patients and ensure their prompt transport to level I trauma centres. The Revised Trauma Score (RTS) is another tool for stratifying the trauma patient based on physiological status, although it has been losing popularity recently on concerns of reliability (Roorda *et al.*, 1996; Gabbe, Cameron & Finch, 2003).

Particular scales exist for specific medical aetiology conditions. Examples include the Cincinnati Prehospital Stoke Severity Scale (Katz *et al.*, 2015) and the Childhood

Asthma Severity Scale (Ortega, 2001). The Emergency Severity Index (ESI) is a generalised patient triaging tool used by emergency department staff. An ESI level 1 patient requires immediate life-saving management (ENA, 2020:9).

3.6.4 Patient prioritisation

Whichever triage tool is used, patients are generally classified into priorities for treatment: high priority (called P1, red code, etc.), mid-priority (P2, yellow code), low priority (P3, green code) and no priority (P4, blue/black/white code). Table 3.5 shows an example of how the triage priority is assigned based on the injury or illness severity. This priority then informs the urgency of care.

Injury/Illness Severity	Priority level	Colour code	Interventions required	Maximum delay allowable until definitive treatment
Severe, immediately life-threatening	**Priority 1** (P1)	Red	Immediate, life-saving	0 – 5 minutes
Serious, not immediately life-threatening but may become so if left too long	**Priority 2** (P2)	Yellow / Orange	Urgent but not necessarily immediate	15 mins – 1 hour
Not serious, not life-threatening	**Priority 3** (P3)	Green	Not urgent, can wait indefinitely	Indefinite, preferably < 4 hours
Deceased, or so badly injured that death is imminent despite medical intervention	**Priority 4** (P4)	Blue / Black / White	No intervention, or palliative care	Not applicable. Dignified peri- & post-arrest management

Table 3.5: Example of prioritisation based on the severity of a patient's injury/illness.

Patients with the highest priority require the most urgent interventions to survive, primarily stabilisation in the prehospital setting followed by rapid transport to hospital, resulting in the earliest definitive care in the emergency department and/or operating theatre. Patients can be reprioritised as their conditions change.

A similar concept worth mentioning here is that of *patient acuity*, which is usually related to the patient's injury/illness severity, and is used by medical resource managers to estimate the levels of care and resource allocation needed in their treatment. They may be classed into high acuity patients (needing the most urgent or intensive levels of management and demanding the most amount of resources, chiefly medical personnel), intermediate acuity, or low acuity (needing minimal resources). Most medical systems, EMS included, have an acuity distribution where the majority of patients are low acuity, some are intermediate acuity, and very few are high acuity.

With this in mind, it is important to remember that EMS does not just deal with the highest acuity patients experiencing the most critical of conditions, but with the whole range of patients, most of whom have less serious conditions and only need limited or non-urgent care and transport for a consultation with a doctor.

In this section I have described the diverse types of patients encountered by EMS staff, as well as a brief overview of the types of life-threatening emergency conditions encountered and their possible severity. I have also shown that a paramedic can rely on various tools and experience to recognise the most serious patients. Throughout this section, I have emphasised the importance of minimising the time to definitive in-hospital care in order to maximise patient survival, especially for the high priority (or high acuity) patient.

3.7 Premises

Based on the empirical descriptions of this chapter, it is clear that the Emergency Medical Services are a complex structure of physical and human resources which exist to fulfil a patient's right of access to healthcare in the prehospital emergency medical setting, by resuscitating and/or stabilising a patient at the scene of an emergency, and transporting them to an appropriate facility for continued, definitive care (premise 2).

It should further be recognised that some types of emergency scenes or medical emergency conditions are time-critical, and by their nature are incompatible with any delay, whilst other emergencies are not as urgent and allow more time for other types of actions to be taken (premise 3).

3.8 Conclusion

In this chapter I have described the aims of an Emergency Medical Services system and given a brief overview of the South African EMS. I have described the unique challenges of the prehospital emergency setting and highlighted the stark differences to the in-hospital environment. I have also described the diversity of patients encountered, along with the diversity of medical and traumatic conditions they present with, and I have discussed how this diversity presents additional challenges for the EMS practitioner. I have described how the severity of an injury/illness affects the mortality risk of a patient, and how, for critical patients, the urgency with which time-sensitive and life-saving interventions are provided has a direct impact on their survival. I have also described the prioritisation of a patient to guide the medic's urgency with which they provide care.

Put simply, the longer it takes to start treatment for critical patients, the worse their survival. Therefore, the priority of the paramedic is rapid stabilisation and transport to definitive care, minimising all delays. In the next chapter, I will argue that because critical patients require the most urgent treatment, any delays incurred by methodically applying all the rights intrinsic in the PRC would adversely affect the outcome of those patients. I will also show how the principles of *Prima Facie* Duties can guide a paramedic in decisions about applying patients' rights in the emergency.

CHAPTER 4: A normative analysis of applying the Patients' Rights Charter in the prehospital emergency setting.

4.1 Introduction

In the previous chapter I have shown the complexities encountered in providing emergency medical care in the prehospital environment when compared to the in-hospital setting. I have also discussed how the severity of a patient's emergency condition, and the urgency with which it requires management, can have a negative impact on their survival. Lastly, I have shown that the primary role of the paramedic is to provide the stabilisation a patient requires in order to transport them to the nearest appropriate health facility for definitive care. Any delay in the provision of this care or transportation for the high acuity life-threatened patient may cause their death: thus, time is the great enemy of the paramedic.

In this chapter I will discuss whether the PRC is usable in the prehospital emergency setting, considering the competing time-related priorities of fulfilling a patient's rights and providing urgent medical treatment and transport. I will highlight the shortcomings of Rights Theory in the context of an emergency, and argue that the theory of *Prima Facie* Duty (PFD) would provide greater flexibility and consideration of the circumstances in the prehospital emergency setting.

4.2 Life: the essential condition for all future rights accrual

Of critical importance, although it seems self-evident, is the preservation of life (alternatively, prevention of death) as a necessary first step to ensuring all future benefit. Overall benefit for the rights-bearing entity (i.e. the patient) depends on bodily integrity and continuation of life because if the entity expires, no further benefit may be accrued. If the application of lower-order rights to the right-bearer causes the right-bearer to cease to exist, then it seems warranted in non-futile cases to temporarily withhold those rights in the overall interest, and to the general benefit of, the rights-bearer. This understanding will form the bedrock of my normative argument to follow.

4.3 The trouble with Rights in the Emergency

At the outset it is worth reiterating the relationship between a right and a duty. Where a right exists, a correlating duty rests on someone to ensure that right for the claimant. The PRC tries to lay out rights that a patient may (and should) claim, whilst simultaneously placing a burden of duty on the practitioner/institution/state to ensure the realisation of those rights. Thus, Rights theory represents a branch of deontological ethics.

Burkholder, Hill and Calvello Hynes (2019) confirm that moral justifications for emergency care systems are supported *by* human rights, but the trouble comes when trying to apply rights *in* the emergency care setting.

The trouble with Rights is that they are onerous to the duty-bearer. They warrant time, attention and resources to be fulfilled in any normal setting. That is why the Bill of Rights (NGSA, 1996) makes repeated use of the phrase "progressive realisation" when it lists many of its rights a citizen can claim. The writers of the Constitution realised that such rights would take inordinate time, planning, effort, commitment and expenditure to manifest. This is the nature of Rights: they are not always easy, quick or simple to ensure, and they are not attained thoughtlessly. If society deems them worthy of enshrining because of the human dignity intrinsic to each person, then they need to be fulfilled with the care and solemnity that dignity deserves.

So much for the complexity in the normal setting. In the emergency setting however, when time is short, attention should be elsewhere and resources are stretched thin, some rights may become too onerous for the duty-bearer.

This is well recognised in international and domestic law in the concept of the *state of emergency* or *state of disaster*. In situations of extreme danger to public health or the stability of a sovereign state, the government is legally permitted to temporarily suspend the majority of the human and civil rights of its citizens. The International Covenant on Civil and Political Rights (ICCPR), adopted by the United Nations General Assembly in 1966 and which the Republic of South Africa ratified in 1998, lists only 7 of its 53 articles which may not be derogated during an emergency "which threatens the life of the nation" (OUNHCHR, 1966: Article 4). The Siracusa Principles

were introduced to provide additional guidance on the limitation and derogation of rights during such a public emergency (UNCHR, 1984).

Similarly in domestic law, section 37 of the Bill of Rights addresses “States of Emergency”, and allows derogation of the rights within the Bill, admittedly “only to the extent that the derogation is strictly required by the emergency” (NGSA, 1996:S37(4)). Paragraph 5 of the same section lists seven non-derogable rights or parts thereof, including the rights to life, equality, dignity, freedom and others. All other rights may be curtailed as is fitting the emergency, in order to allow the state to place its full focus on managing and mitigating the emergency.

The moral justification for such drastic measures is surely Utilitarian. Services or resources that are considered as basic and are usually allocated for the day-to-day general enjoyment of the populace may be reassigned immediately in the case of national emergency, without any reparation for lost benefit. The inconvenience of a few (or even of many) is necessarily outweighed by the potential for benefit in a crisis. An example of this has be seen during the Corona virus global pandemic of 2020, where elective elements of healthcare services were suspended and reassigned to crisis-specific facilities like field hospitals for Corona positive patients.

If this utilitarian-type adjustment is available to deontological-type human rights during a national emergency, it is surely feasible to apply the same principle of curtailment to the lesser patients’ rights during a serious personal medical emergency, where the benefits lost are greatly outweighed by the benefits gained.

Consider the following emergency scenario from the viewpoint of not suspending certain rights:

> A 25-year-old male migrant labourer has been stabbed in the neck during a night of drinking. The knife was removed by bystanders, and bright red blood can be seen spurting rhythmically from the wound indicating a severed carotid artery. He is awake but drowsy, is in pain, is looking pale, and has the smell of hard alcohol on his breath. His friend tells you he is on antiretroviral treatment for HIV/AIDS. The Police services have still not arrived and the bystanders in the bar are getting rowdy - another fight breaks out across the room. The scene is equidistant between two hospitals, one of which is a trauma centre. It becomes evident that

you do not share a common language with the patient. A second ambulance service arrives, staffed by Basic providers.

Attempting to apply the patients rights as stipulated by the PRC to the above scenario reveals the following:

- A healthy and safe environment: this is an uncontrolled setting requiring police presence. It is uncertain when the police will arrive. Until they do, what time and resources should the paramedic allocate to trying to control an unruly crowd?
- Health information in the patient's language, that is full and accurate as a prerequisite for informed consent. This would require the service of a reliable interpreter and an extensive two-way conversation between patient and paramedic via the intermediary.
- Participation in decision-making: the patient is under the influence of alcohol and has an injury that will result in diminishing blood flow to the brain and a progressive decrease in level of consciousness. Participation by the patient will be fleeting and less than meaningful.
- Special provision for patients with HIV/AIDS and those in pain: What special provisions, and what time and resources should be allocated to this?
- Choice of health services: the patient must choose which ambulance service to engage without knowledge of the scopes of the paramedics, and choose which hospital is preferable. Both choices would need significant additional, pertinent information.
- Second opinion: the patient could request the second ambulance crew to perform their assessment with additional informed consent, and advise on treatment and destination hospital, at the cost of additional time.

The above scenario may seem heavy-handed but consider the following: the patient may be losing around 450 millilitres of blood every minute through the severed artery (Uematsu *et al.*, 1983:259); an adult male's total blood volume is approximately 5 litres (Sharma & Sharma, 2020); and, that life-threatening shock can occur from blood loss greater than 30% of total volume (Johnson & Burns, 2020). This is a life-threatening injury, and his survival depends on *immediate* haemostasis (i.e. prevention of further blood-loss) and *urgent* surgical damage control, ideally within minutes. The

methodical and unadjusted application of the PRC will swallow up these essential minutes to the patient's detriment and unavoidable death.

It seems intuitive that a paramedic may ethically withhold or delay the provision of a patient's rights in favour of providing life-saving intervention. An example of precedent beyond intuition may be found in the Emergency Medicine Society of South Africa (EMSSA)'s ethical standards, which states: "Emergency Care Personnel shall… secure [a patient's] informed consent for treatment (unless the urgency of the patient's condition prevents this)" (EMSSA, 2008:3). On the same topic the NHA section 7(1)(e) provides a legal basis, where treatment without consent may be started if "any delay… might result in his or her death or irreversible damage to his or her health" (NGSA, 2004). If informed consent can be suspended under certain circumstances, the question should be asked: which other rights may be as well?

However, there is no explicit clause of the PRC which states this principle: that a patient's rights may be temporarily suspended in favour of life-saving treatment. Nor is there any direction on which are the dispensable rights. Without a clear statement, the paramedic is stuck on unfirm ground, trying to balance rights with a patient's best outcome, but without any assurance that their decisions are permissible, let alone ethical. What is needed is a morally justifiable approach to the PRC which allows the paramedic to incorporate situational variables in order to know when to spend time fulfilling a patient's rights and when to curtail them. I propose that W.D. Ross's *Prima Facie* Duties offer such an approach.

4.4 *Prima Facie* Duties

Before examining the core features of *Prima Facie* Duties (PFD), it is important to examine what jurisdiction it may have in respect of the theory of Rights. It is accepted that where a right exists, a correlating duty rests on someone to ensure that right. When the Patients' Rights Charter lays out rights that a patient may claim, it simultaneously lays a burden of duty on the practitioner to ensure the realisation of those rights. With this in mind, it becomes evident that a framework concerning duty, like Ross's *Prima Facie* Duties, may be extrapolated into circumstances where only the right is explicitly stated, like the PRC. The right's duty-bearer, because of his duty, may now be examined deontologically.

The doctrine of *Prima Facie* Duty was proposed by Sir William David Ross, the Scottish philosopher and Oxford academic. Ross was dissatisfied with the two predominant ethics theories of the early 20th century, being deontology and teleology, as sufficiently robust standalone theories. To Kant's deontology he attributed "ideas of duty, of right and wrong, of moral law…, of imperatives" (Ross, 1939:3). Here the weight lay on the moral agent to discern their moral duty and perform it unswervingly, with no consideration of the possible undesirable consequences of the action. Such automatic adherence to a set of rules, to doing the "right" thing, with no consideration paid to the circumstances often produced results that were clearly immoral.

He was no more enamoured with the teleological theory where the consequences of an action became the ultimate factor of consideration when identifying the moral action. He called this the "Greek ideal" in which the "supreme end [was] to secure, both for oneself and for others, a life [of] good activity and pleasure" (1939:4). His complaint was that ideal Utilitarianism artificially simplified our interpersonal relationships, "that the only morally significant relation in which my neighbours stand to me is that of being possible beneficiaries by my actions" (Ross, 1930:19), which he disputed.

On this disharmony between the theories, he states: "both the [deontological] notion of right and the [consequentialist] notion of good are implied in the study of moral questions, and any one who tries to work with one only will sooner or later find himself forced to introduce the other" (1939:5). He concluded: "It would indeed be strange if any of the main theories of ethics were completely in error; it is far more likely that each has grasped something that is both true and important but has, … by some apparently trivial logical error, claimed as the whole truth what is only one of a set of connected truths" (1939:2).

This recognition of the interconnectedness of ethical theories classed him as an ethical Pluralist, although leaning more towards moderate deontology (see Timmons, 2003; Skelton, 2012; and Brink, 2013). He based his ethical theory on Moral Intuitionism, as he felt that people just knew what was right because of an intrinsic sort of moral knowledge or intuition. "What comes first in time [when we have reached sufficient maturity to think in general terms] is the apprehension of the self-evident *prima facie* rightness of an individual act" (Ross, 1930:33). His use of concepts like apprehension

and self-evidence were unsatisfactory to his critics, although his arguments of how the "plain man" is able to arrive at correct moral decisions without with the conscious application of ethical theory (in other words, by intuition) is compelling. He admonishes: "The existing body of moral convictions of the best people is the cumulative product of the moral reflection of many generations, which has developed an extremely delicate power of appreciation of moral distinctions" (Ross, 1930:41).

His chief contribution to ethics was a set of non-hierarchical, deontological-type duties which were morally binding unless it became circumstantially apparent that other duties were weightier. He called these "*prima facie*" or "conditional duties" (Ross, 1930:19) so named because they appeared at first to be the obvious incumbent duties, but which may be displaced on careful reflection by other (possibly conflicting) duties. These other, weightier duties become the "duty proper" or the morally binding duty, which Ross calls "duty *sans phrase*" (1930:19). It is only through careful examination of the situation with "all things considered" and with special attention to outcomes, that one is able to discern the duty proper from among the collection of *prima facie* duties. Valuably, consideration of a similar but materially different situation may produce a completely different duty proper for the moral agent. It is this adaptability which suits PFD to application in the emergency setting.

Ross lists seven *prima facie* duties, which he does not claim to be complete or final, and which hold no intrinsic rank over the other (with one exception) (1930:20-22):

- Fidelity, concerned with truth-telling and promise-keeping;
- Reparation, making up for previous wrongful acts;
- Gratitude, in response for the good acts or services of others;
- Justice, which Ross defines as not allowing unmerited gain or benefit to occur;
- Beneficence, where other's situations or states may be improved;
- Self-improvement, to strive to improve our own situations or states (especially those of virtue and intelligence);
- Non-maleficence, of not harming or allowing harm to come to others.

Ross acknowledges that non-maleficence may be argued to be a facet of beneficence, but intentionally separates the two because he feels that this allows the two *prima facie* duties more opportunity to come into conflict, in which case he advocates that

non-maleficence should be considered the weightier (1930:22). Other commentators have added to the list (at Ross's invitation) (see Garrett, 2004, for instance), with proposed *prima facie* duties like *care*, *respect for freedom* and *non-parasitism*, but for the purposes of this research report I have preferred to adhere to the original seven.

Ross's form of ethics seems to have one foot in each moral camp, so it feels much more flexible than deontology alone, and much less hedonistic and whimsical than consequentialism alone.

This clash of ethical theories is echoed in conflicting aims of the PRC and the EMS: the core of the PRC is clearly deontological (being based on theory of Rights), whilst emergency medical care is preoccupied with outcomes and hence nests well with consequentialism. With this crossover of competing priorities, I feel that PFD offers the middle road (and a certain mediation) between the two ethical standpoints. How then can PFD be applied usefully to the PRC?

4.5 Application of *Prima Facie* Duties to the Patient's Rights Charter

To begin our superimposition of PFD onto the PRC, it is useful to match each right to a reasonable *prima facie* duty it implies on the duty-bearer. One will note in Table 4.1 below that the majority of rights reference *beneficence*, as can be expected in the healthcare services. One will also note that fidelity, or promise-keeping, is the *prima facie* duty linked to every right/duty, which I discuss below.

Patients' Rights as per the PRC	Correlating *Prima Facie* Duty
A healthy and safe environment	Fidelity Beneficence Non-maleficence Justice
Participation in decision-making	Fidelity Beneficence
Access to healthcare	Fidelity Beneficence
Knowledge of one's health insurance / medical aid scheme	Fidelity Beneficence
Choice of healthcare services	Fidelity Beneficence
Be treated by a named healthcare provider	Fidelity Beneficence
Confidentiality and privacy	Fidelity Non-maleficence
Informed consent	Fidelity Beneficence Non-maleficence Justice
Refusal of treatment	Fidelity Non-maleficence
Be referred for a second opinion	Fidelity Beneficence
Continuity of care	Fidelity Beneficence Non-maleficence
Complaint about health services	Fidelity Reparation

Table 4.1: Correlation of Patients' Rights Charter rights to *Prima Facie* Duties
Note that the rights as listed above are drawn from the headings of the PRC and are taken at face-value to infer the ideal incarnation of the right in question.

As Ross expends much argument on the *prima facie* duty of fidelity as it pertains to promise-keeping, it is worth considering whether the paramedic holds any special duty of fidelity to her patient. The answer is obviously yes, both because of the professional relationship engaged in (that of patient and healthcare provider), but also because of the Paramedic Oath (Gillespie, 1978) that each new graduate recites on admission to the profession. Based on the Hippocratic Oath, with several versions in use internationally, it reads:

> *Be it pledged as an Emergency Medical Technician, I will honor (sic) the physical and judicial laws of God and man. I will follow that regimen which, according to my ability and judgment, I consider* ***for the benefit of patients*** *and* ***abstain from whatever is deleterious*** *and mischievous, nor shall I suggest any such counsel. Into whatever homes I enter, I will go into them for the benefit of only the sick and*

injured, never revealing what I see or hear in the lives of men unless required by law.

I shall also share my medical knowledge with those who may benefit from what I have learned. I will serve unselfishly and continuously in order to help make a better world for all mankind.

While I continue to keep this oath unviolated, may it be granted to me to enjoy life, and the practice of the art, respected by all men, in all times. Should I trespass or violate this oath, may the reverse be my lot.

So help me God.

Box 4.1: The Paramedic Oath (bold mine)

Declared solemnly before their peers, this surely may be viewed as a promise to their future patients *in absentia* concerning their benefit, non-maleficence, confidentiality, provision of information, and commitment to service. These commitments underpin the PRC rights well, and hence, I feel I am correct in allocating fidelity to all of the PRC's rights/duties which include these elements.

If the paramedic is bound to the provision of the rights of the PRC by fidelity and beneficence, how is it morally justifiable to suggest that those rights be limited or abandoned in certain circumstances? Thus, we approach the initial part of the central moral question posed by this research report: should the PRC be applied in its entirety to the emergency medical setting?

I would argue that fidelity, beneficence and non-maleficence morally mandate the limitation of rights in the medical emergency. Let me address beneficence first.

I have already shown that the intent of the PRC is one of beneficence and non-maleficence. One could think of it as encapsulated in a cloud of beneficence, producing a general or holistic type of benefit to the patient: they receive courteous treatment, they gain understanding, they feel included in decision-making, their value is affirmed when complaining, etc. All of this is good and desirable, and should be a moral aim under normal circumstances.

However, the patient with a life-threatening condition requires a specific benefit (e.g. opening an airway, stopping the bleeding, etc.), not a general benefit which takes time

to fulfil. If the general benefit delays or interferes with the specific benefit, then it is not beneficial at all, but rather it is harmful. Stated differently, the *prima facie* duty of (general) beneficence conflicts with that of non-maleficence against the harm its institution would produce. Thus, non-maleficence now becomes the duty proper and hence disallows the application of the general form of beneficence intended by the PRC. See Figure 4.1 for a visual interpretation.

Similarly, in terms of fidelity, the paramedic has a general form of fidelity to uphold the PRC by dint of being a professional healthcare worker, as obliged by the Department of Health. The aim again is the general benefit to the patient through the rights contained within the PRC. However, the paramedic also has a specific form of fidelity directly to the patient to ensure their specific benefit, by dint of their Oath spoken before their peers on admission to the profession. This includes the abstinence from actions that are “deleterious”. The *prima facie* duty of fidelity to the patient outweighs the duty of fidelity to the PRC, and the former becomes the duty proper.

Thus, the paramedic is justified by three mechanisms to provide care over rights: firstly through specific fidelity (to the patient) to cause a specific benefit; secondly through beneficence itself which results in the specific benefit to the patient; and thirdly, through non-maleficence to prevent any harm a delay to the specific benefit would cause through the application of general benefit (via the PRC).

It is interesting to note that the conflict does not arise between fidelity and beneficence, but rather homogenously between general and specific fidelity, and subsequently general and specific beneficence.

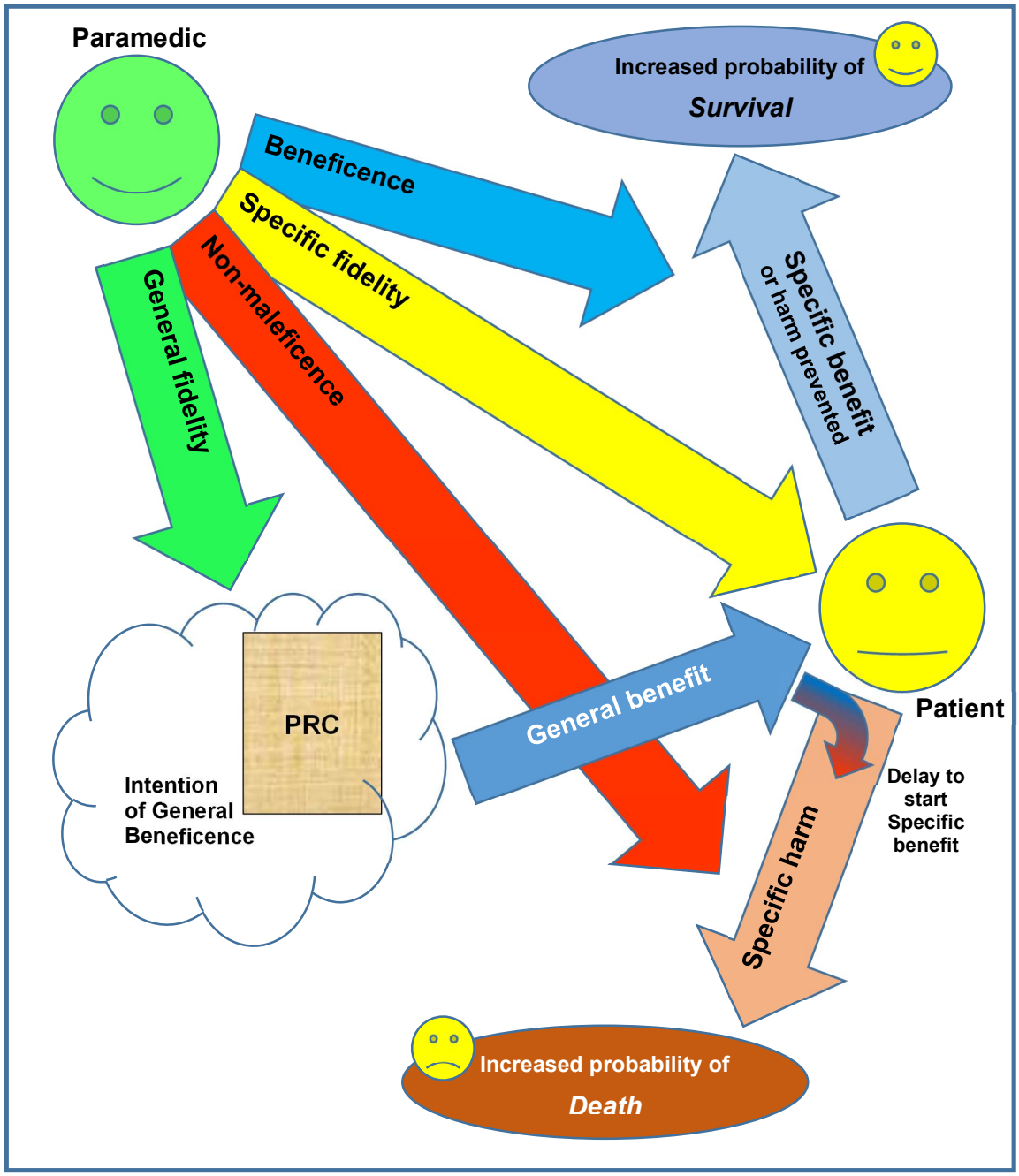


Figure 4.1: Interactions of *Prima Facie* Duties in the life-threatening emergency

Key: PRC – Patients' Rights Charter

In summary, the weightiest incumbent duty on the paramedic in the life-threatening emergency is towards the patient and not towards the PRC, because the specific benefit of withholding rights in order to start treatment greatly outweighs the general benefit to the whole person intended by the PRC. Thus, the physical benefit and avoidance of potential harm incurred by the patient is the primary moral and professional concern of the treating paramedic, and in the truly life-threatening emergency, she is morally justified in abandoning the application of rights (at least until the threat to life has passed).

Prima Facie Duty highlights the analysis of circumstances as vitally important. It is reasonable therefore, in non-life-threatening emergencies where there is no (or little) risk of the patient sustaining harm, that the paramedic is morally bound to apply the rights as published in the PRC from the outset of the patient-practitioner interaction. I will provide addition detail on operationalising PFD in the next chapter, and we will return to the above scenario with its optimal outcome under the PFD approach.

Lastly, in support of the above, precedent already exists within the Rights movement (on both moral and legal grounds) to suspend lower-order rights during extreme emergencies (see the BoR and ICCPR).

4.6 Premise

In the above discussion I have shown how the emergency medical practitioner, being informed by careful analysis of the circumstances as proposed under *Prima Facie* Duty theory, is justified to dynamically prioritise one moral duty over another/others.

4.7 Conclusion

In this chapter I have critically evaluated the feasibility of applying the Patients' Rights Charter in its entirety in the prehospital emergency setting, in the light of the variable nature and severity of the emergency situations and conditions encountered. I have shown that Rights are onerous on the duty-bearer, and may interfere or distract the paramedic from performing life-saving interventions for the highest acuity patients. It is therefore unfeasible to expect the complete application of the PRC (as published) in the life-threatening emergency setting.

I have articulated and defended the normative justification of an emergency practitioner in forgoing certain of the patient's rights as listed in the PRC, in favour of providing timely emergency medical care and transport, with particular reference to the theory of *Prima Facie* Duty. I have argued that despite the *prima facie* beneficence intended by the PRC, on closer examination, the complete application of a critical patient's rights results in damage to the patient, and thus the *prima facie* duty of non-maleficence becomes the duty proper, and morally compels the paramedic to perform life-saving interventions first and foremost. Complete Rights fulfilment for intermediate and low acuity patients should be applied as intended by the PRC.

In the following chapter I will address the suitability of the PRC to the pre-hospital setting, along with a proposal for an alternative to the PRC: the *Patients' Emergency Rights Charter (PERC)*.

CHAPTER 5: The Patients' Emergency Rights Charter

5.1 Introduction

In the last chapter, I showed the shortcomings of applying Rights in the emergency setting by trying to fulfil the PRC in a hypothetical emergency scenario. I discussed how rights are often suspended in an emergency, and I described how the approach provided by W.D. Ross's *Prima Facie* Duties proved more responsive to circumstantial factors than Rights alone. I also justified the moral decision to withhold or curtail a patient's rights in a truly life-threatening emergency in favour of providing the emergency care necessary to prevent permanent physiological damage and/or death.

In this chapter, I will draw together the points I have argued throughout the earlier chapters, by proposing an alternative to the PRC, namely the *Patients' Emergency Rights Charter* (PERC) suitable for application within the prehospital emergency setting, with minimal additional interpretation required. I believe that the tailored PERC will provide useful guidance to both the patient and the emergency provider, and strike the correct balance between ensuring the patient benefits from the provision of reasonable rights in the emergency, and the provision of time-sensitive emergency medical care and transport.

5.2 The Patients' Emergency Rights Charter

As I have shown in chapter 2, the Patients' Rights Charter was written predominantly for the "in-facility" setting, which includes hospitals, clinics, healthcare practitioners' rooms, etc. I also showed how it suffers from a confusing structure and unclear wording, which leaves gaps and misleading expectations in the rights implied by the document. In chapter 3, I have shown how prehospital emergency care is vastly different from the in-hospital setting, in terms of patients, resources and timing. In chapter 4, I have shown how the PRC does not perform well when applied in the prehospital emergency setting. I conclude that the PRC as published is not suitable for application in the prehospital emergency setting, and this necessitates an alternative document which is clearer, more complete, and requires little additional

interpretation in the emergency. This is in line with Nevhutalu's recommendation for developing "specific rights charters" for niche patient groups or situations (2016:206).

To this end I propose the *Patients' Emergency Rights Charter* in Box 5.1 below.

The Patients' Emergency Rights Charter (PERC)

Preamble: Emergencies by definition are uncontrolled and time-restricted. The Emergency Medical Services (EMS) exist to provide quality medical care and transport in such events. The majority of emergencies are minor, but some will threaten the life of the patient: in such cases some of the below rights may be unwise or impossible to fulfil whilst also providing urgent, life-saving treatment and transport. In these extreme life-threatening cases, it is ethically acceptable for the Practitioner to withhold some rights (tier 3) in favour of providing such time-critical, life-saving treatment and transport as needed.

Tier 1: "Pre-arranged rights" may be catered to ahead of time, and will always apply to every emergency scene. Under this tier, emergency patients have the right to:

- A healthy and safe Ambulance environment. The vehicle and equipment will be clean and in working order.
- Be treated by a named healthcare provider. Practitioners will wear a nametag which also reflects their role/rank.
- Complain, and receive a timely response. A complaints flowchart detailing the entry point and process should be posted on the ambulance wall beside the patient stretcher.

Tier 2: "Entrenched rights" will be provided at the time of the incident, and will always apply to every emergency scene. Under this tier, emergency patients have the right to:

- Quality emergency care. Practitioners should be well trained, registered with the HPCSA, operate under the latest scope of practice, be regularly reviewed and mentored when necessary.
- Dignified interaction. The practitioner should be polite and positive.
- Give mere consent. The patient, or a legally acceptable surrogate, must give permission for assessment and treatment in an acceptable way, namely written, verbal, or through body motion. Unconscious patients will be assumed to have given implied consent.
- Confidentiality. Practitioners will ensure that a patient's information is protected from unauthorised persons.

- Continuity of care. Patients will be passed from healthcare provider to healthcare provider along an accepted therapeutic pathway until their discharge, without any instance of perceived abandonment occurring.
- Give mere refusal of care. Unless limited by law, a patient may refuse any and/or all assessment and treatment without explanation from the outset, or at any time during assessment or treatment.

Tier 3: "Situational rights" will be provided at the time of the incident, but will only be conditionally applied depending on the type and severity of the emergency, on available time and other circumstantial factors. Non-life threatening emergencies warrant full application, whilst life-threatening emergencies warrant as full an application of as many rights as is deemed possible at the time. Under this tier, emergency patients may have the right to:

- A healthy and safe scene. Practitioners must mitigate hazards rapidly where possible, or remove the patient rapidly where possible. Unsafe scenes do not warrant patient treatment.
- Timely emergency care. EMS should get emergency resources to a patient depending on their criteria in such a way that the patient does not suffer additional harm by waiting. Similarly, patients should be moved promptly to hospital when warranted.
- Complete health information in a language the patient understands, including the nature of one's injury or illness, diagnostic procedures, proposed treatment, possible complications and expected costs.
- Informed consent. Once all health information is understood, permission must be given to commence assessment and treatment.
- Informed refusal of care. Similarly, unless limited by law, permission may be denied once all health information is understood.
- Involvement in decision-making. Ongoing information should flow to a competent patient in order to facilitate their participation in decisions which affect their health.
- Choose their healthcare service provider. Where more than one Practitioner of the appropriate rank is available on scene, the information needed for an informed choice should be included as part of the right to complete health information above.
- A second opinion. Where more than one Practitioner of the appropriate rank is available on scene, the patient may request their opinion, which should be forthcoming.

- Privacy. As dictated by the scene, Practitioners should make every effort to ensure the privacy of the patient during assessment, treatment and transport.
- A positive disposition displayed by the healthcare provider. Practitioners should exhibit patience, empathy and courtesy.

Box 5.1: The Patients' Emergency Rights Charter

5.3 "Weighing-up" and application of the PERC

Drawing on Ross, two opportunities exist for conducting a "weighing up" of the relevant *prima facie* duties incumbent in the emergency setting, and both are necessary for valid use of the PERC. I have termed them "pre-weighing" and "re-weighing".

"Pre-weighing" is a generalised, theoretical analysis ahead of time of realistically anticipated types of emergencies, both life-threatening and non-life-threatening. This would be performed by national EMS sector advising- and/or regulating bodies, thereby ensuring standardisation across all EMS service providers. Stakeholders would evaluate the emergency rights through the predominant *prima facie* duties of fidelity, beneficence and non-maleficence regarding hypothetical life-threatening and non-life-threatening emergencies, and issue a generalised structure on what is morally acceptable and expected practice in each type of case. This is the process I have gone through in order to produce the three tiers of the PERC, resulting in a framework of ready-to-use rights based on highly probable future emergency situations. Future EMS stakeholders may add, reorder or reclassify rights to different tiers as they go through reiterative "pre-weighing" cycles.

"Re-weighing" is a rapid, onsite, contextual analysis by the treating paramedic, incorporating all of the situational variables observed, on a case-by-case basis. This real-time re-weighing of the incumbent *prima facie* duties at the patient's side allows the practitioner to decide if the emergency condition actually is life-threatening and, if so, to activate the option to dispense with tier 3 rights in favour of providing life-saving care. This secondary analysis verifies the conclusions reached in the pre-weighing process, and confirms the current case as eligible for reduced rights/duties application. To aid the practitioner in this "re-weighing" I offer the following simple but effective tool:

Is this patient dying?

Despite the obvious simplicity of the question, this is a verified tool that helps emergency triage personnel recognise when time-critical actions need to be taken in order to reduce the risk of death (ENA, 2020:13). This same question is the entry point into the Emergency Nurses Association (ENA) Emergency Severity Index (ESI) triage algorithm, which was used by 57% of American Hospital Association's members in 2009 (McHugh, Tanabe, Khar & McClelland, 2011), and can be seen in Figure 5.1 below.

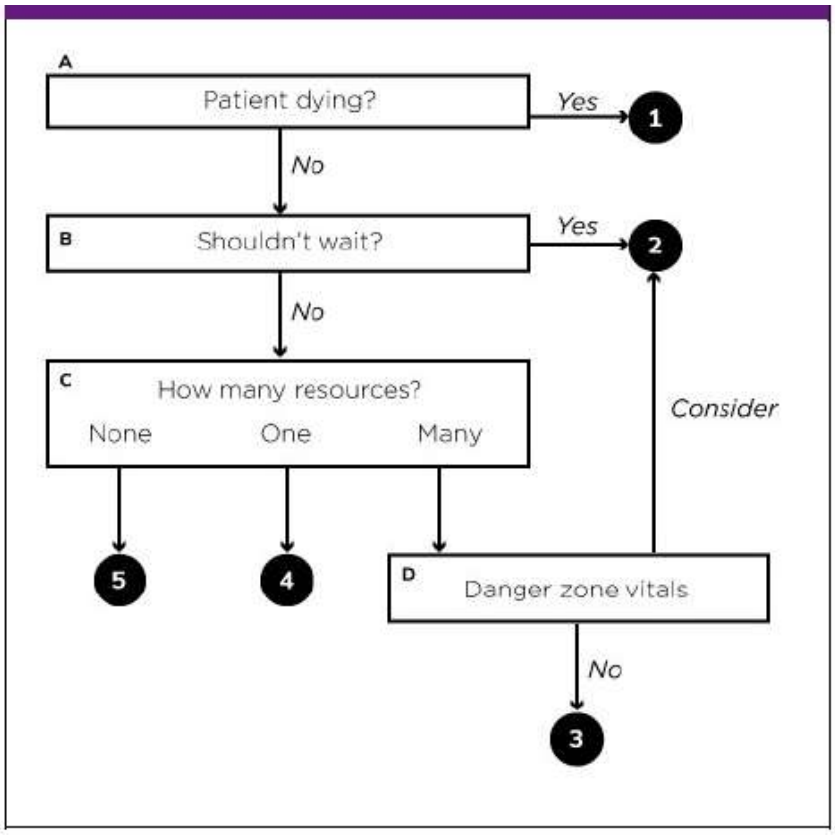


Figure 5.1: The Emergency Severity Index Conceptual Algorithm

Source: ENA Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4 Implementation Handbook 2020 Ed. Pg17. Used with permission.

Thus, with minimal delay, the practitioner can employ this simple tool to recognise a life-threatening situation which frees the paramedic from focussing on providing tier 3 rights/duties, but rather channels attention and resources to providing emergency care for stabilising and transporting the patient in the shortest time possible.

Let us reconsider the scenario offered in chapter 4 with the application of the PERC:

- The arrangements for tier 1 (pre-arranged) rights will have already been made, meaning these rights are unobtrusively active throughout and require no additional attention.
- Tier 2 (entrenched) rights are offered with little additional effort beyond the PERC-influenced standard operating procedures of an EMS service. The patient may nod at a request to treat (mere consent), would then benefit from immediate quality care, and look forward to being handed over to a pre-alerted emergency department (continuity of care). There is no delay to life-saving treatment at this tier.
- The paramedic conducts the "re-weighing" situational analysis and establishes that, without immediate intervention, the *patient is dying*. This classes the emergency as life-threatening and offloads the tier 3 (situational) rights from the paramedic, essentially freeing him to commence life-saving treatment without the moral pressure to fulfil all outstanding rights first. This is appropriate and correct, as one can easily see the delay incurred should tier 3 rights like "full information", "*informed* consent", "involvement in decision-making", "choice of healthcare provider" and "second opinions" be fully applied.
- Haemostasis interventions would be started as soon as the patient gives mere consent, followed by rapid removal from the unsecured scene to the ambulance, followed by expedited transport to the trauma centre, without making any of these actions dependent on the reduced-capacity patient's interpretation and decision-making.
- Should the life-threatening condition be adequately controlled so it is no longer a threat (unlikely in this scenario), the paramedic may then return to tier 3 rights and fulfil them as is fitting. Similarly, in a different situation, where the answer to the "re-weighing" question is "no, the patient is not dying", then tier 3 rights would be offered from the outset and throughout.

From the above, one is able to appreciate the value of a rights charter tailored to the prehospital emergency setting, such as the PERC.

5.4 Conclusion

In this chapter I have reiterated the unsuitability of the Patients' Rights Charter (as published) to the prehospital emergency setting. I have proposed an alternative charter, the *Patients' Emergency Rights Charter (PERC)*, which would guide claimants (patients) and emergency practitioners in the rights applicable to the emergency setting, and present those rights in a way that will require limited additional interpretation for application within the emergency medical environment.

With this PERC I have tried to trim away rights inapplicable to the emergency setting and provide clarity and refinement to others, such that they are useful and practicable for the practitioner to provide. I have also separated the emergency rights into three tiers to assist EMS providers in their preparation and delivery of these rights, and I have allowed for the truncation or withholding of tier 3 rights when the situation is deemed life-threatening, in order to prioritise life-saving treatment and transport. Lastly, I have provided a simple test to assist the practitioner to know when tier 3 rights are required in totality and when they are not.

In the next chapter I will provide a summary of my premises, my conclusion and my thesis.

CHAPTER 6: Conclusion

Humans, by virtue of their humanity, possess an intrinsic dignity. This dignity deserves respect, and that respect manifests in the allocation of rights. These rights range from inviolable rights to life, freedom and security of their person, to social, political and collective rights like the right of access to healthcare. The South African Government has declared this right (and others) in the Bill of Rights, chapter 2 of the National Constitution (NGSA, 1996).

The National Department of Health, in their mandate to promote, protect and fulfil this right of access to healthcare, published their National Patients' Rights Charter (PRC) in 1999 "as a common standard for achieving the realisation of this right" (NDH, 1999b:1). It comprises approximately twenty-five rights a patient may expect, under twelve headings, and lists ten responsibilities the patient should commit to in order to obtain the greatest benefit from the health system.

However, the current PRC is required to cater to the entire range of healthcare services and settings, and hence describes these patients' rights in very broad terms. For the most part, this generalised format of the PRC is suitable and readily applicable in the greater part of the healthcare system: in healthcare facilities, where care is provided within purpose-built facilities, under controlled conditions. Care is mostly of a non-emergency nature, and time and resources are available to prepare for, and facilitate, the patient through a pathway of managed care.

My concern is that the PRC may be unsuitable for application in the prehospital emergency environment, where the setting is uncontrolled, time-pressured, and occupied with providing life-saving care to the highest acuity patients, for whom the slightest delay may prove fatal. Unfortunately, the PRC offers no guidance on how to interpret or apply a patient's rights in the prehospital emergency setting. Furthermore, there is a significant paucity of empirical and normative literature concerning the application of patients' rights within the in-facility healthcare setting, and no literature exists in applying it in the prehospital emergency setting.

In light of this, my research question was: Should the South African National Patients' Rights Charter be applied in its entirety to the prehospital emergency medical setting,

and if not, which patient rights should the emergency practitioner dedicate time and effort to upholding, and which rights are morally dispensable in favour of providing timely emergency medical care and transport?

My aim was to articulate and defend the proposition that the PRC is inadequately suited to being applied in the prehospital emergency medical setting, and that in certain time-critical, life-threatening emergency situations, the emergency practitioner would be morally justified in dispensing with some of the patient's rights in favour of providing timely emergency medical care and transport.

To achieve this aim, in chapter 2, I identified the prescriptive purpose of the PRC and critically evaluated its suitability and efficacy in attaining that purpose in general, with particular reference to Rights Theory. I concluded that the PRC exists to promote the rights and interests of all patients in South Africa, especially the right of access to healthcare, and places a burden of duty on the second party (the practitioner or state) to protect and fulfil these rights (my first premise).

In chapter 3, I compared the prehospital emergency medical environment with the non-emergency in-hospital environment and highlighted their key differences. I described some common medical and traumatic conditions encountered, along with their severity, time-sensitivity and potential for harm. I concluded that the Emergency Medical Services exist to fulfil the right of access to healthcare in the prehospital emergency medical setting, by resuscitating and stabilising a patient at the scene of an emergency, and transporting them to an appropriate facility for continued, definitive care (my second premise). I also concluded that some types of life-threatening emergency medical conditions are time-critical, where delays would produce material harm, whilst other emergencies are not as urgent (my third premise, part A).

In chapter 4, I critically evaluated the feasibility of applying the PRC in its entirety in the prehospital emergency setting, in the light of the variable nature and severity of the emergency situations and conditions encountered, and concluded that time-sensitive, life-threatening types emergency medical are incompatible with the complete fulfilment of the requirements of the PRC, whilst less-urgent emergencies allow a more methodical application of the patient's rights (my third premise, part B).

I also articulate the normative justification of an emergency practitioner forgoing certain patient's rights in favour of providing timely, life-saving emergency medical care and transport, by considered application of the theory of W.D. Ross' *Prima Facie* Duty. I concluded that through careful analysis as proposed under *Prima Facie* Duty theory, it is morally permissible under certain circumstances for the prioritisation of one duty over others (my fourth premise).

To this end, the conclusion of my research report is that in certain circumstances deemed life-threatening, it is morally permissible for an emergency practitioner to forego sections of the Patients' Rights Charter in the prehospital emergency setting, in order to facilitate emergency medical treatment and transport for certain categories of serious, time-critical conditions. The circumstances require careful analysis and would include the consideration of the emergency medical condition afflicting the patient, along with a weighing-up of the benefit of the time invested in providing a patients' lower order rights versus the detriment incurred due to the resultant delays to life-saving treatment and transport.

Thus, I present my thesis, that the South African National Patients' Rights Charter is inadequately suited to application within the prehospital emergency medical setting, and in certain time-critical, life-threatening emergency situations, the emergency practitioner ought to dedicate *some* time and effort to upholding *selected* patient's rights, but is morally justified in dispensing with others, or dealing with them superficially, in favour of providing timely emergency medical care and transport.

To assist the practitioner in recognising which rights may be curtailed, I recommend the adoption of a niche rights charter for the prehospital emergency setting. To this end, in chapter 5, I proposed an alternative charter, the *Patients' Emergency Rights Charter (PERC)*, which guides patients and emergency practitioners in the rights applicable to the emergency setting, and requires limited additional interpretation for application within the emergency medical environment. I offer the *Patients' Emergency Rights Charter* for critical consideration by the healthcare ethics community.

Body word count: 20,342

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Appendix A: The South African Patients' Rights Charter

THE PATIENTS' RIGHTS CHARTER

For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. To ensure the realization of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this *PATIENTS' RIGHTS CHARTER* as a common standard for achieving the realization of this right.

This Charter is subject to the provisions of any law operating within the Republic of South Africa and to the financial means of the country.

A HEALTHY AND SAFE ENVIRONMENT

Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.

PARTICIPATION IN DECISION-MAKING

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health

ACCESS TO HEALTHCARE

Everyone has the right of access to health care services that include:

i. receiving timely emergency care at any health care facility that is open regardless of one's ability to pay;
ii. treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
iii. provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, person living with HIV or AIDS patients;
iv. counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;
v. palliative care that is affordable and effective in cases of incurable or terminal illness;
vi. a positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance; and
vii. health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

KNOWLEDGE OF ONE'S HEALTH INSURANCE/MEDICAL AID SCHEME

A member of a health insurance or medical aid scheme is entitled to information about that insurance or medical aid scheme and to challenge, where necessary, the decisions of such health insurance or medical aid scheme relating to the member.

CHOICE OF HEALTH SERVICES

Everyone has the right to choose a particular health care provider for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such health care providers or facilities, and the choice of facilities in line with prescribed service delivery guide lines.

BE TREATED BY A NAMED HEALTH CARE PROVIDER

Everyone has the right to know the person that is providing health care and therefore must be attended to by clearly identified health care providers.

CONFIDENTIALITY AND PRIVACY

Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court.

INFORMED CONSENT

Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects anyone of these elements.

REFUSAL OF TREATMENT

A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

BE REFERRED FOR A SECOND OPINION

Everyone has the right to be referred for a second opinion on request to a health provider of one's choice.

CONTINUITY OF CARE

No one shall be abandoned by a health care professional worker or a health facility which initially took responsibility for one's health.

COMPLAIN ABOUT HEALTH SERVICES

Everyone has the right to complain about health care services and to have such complaints investigated and to receive a full response on such investigation.

EVERY PATIENT OR CLIENT HAS THE FOLLOWING RESPONSIBILITIES:

- Advise the health care providers on his or her wishes with regard to his or her death.
- Comply with the prescribed treatment or rehabilitation procedures.
- Enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.
- Take care of health records in his or her possession.
- Take care of his or her health.
- Care for and protect the environment.
- Respect the rights of other patients and health providers.
- Utilise the health care system properly and not abuse it.
- Know his or her local health services and what they offer.
- Provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.

National Department of Health: Private Bag X828, Pretoria. 0001. Telephone: 012 395 8264/3
www.doh.gov.za

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Source: https://www.idealclinic.org.za/docs/Posters/PATIENTS%20RIGHTS%20CHARTER%20-%20Eng.pdf [Accessed 8 March 2018]

Appendix B: Ethics Waiver

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

Ref: W-CP-181207-3

07 December 2018

TO WHOM IT MAY CONCERN:

Waiver: This certifies that the following research does not require clearance from the Human Research Ethics Committee (Medical).

Investigator:	**Mr Stuart Hackland (student no 1761718)**
Supervisor:	**Fr Anthony Egan**
Faculty:	Health Sciences
School:	Clinical Medicine
Department:	Steve Biko Centre for Bioethics
Project title:	**Moral obligation or medical obstacle: Is the patients' rights charter fit for purpose in the prehospital emergency setting?**
Reason:	Literature Review - A review of information in the public domain for MSc (Med) Bioethics and Health Law, no humans, human data or human tissues will be used.

Dr Clement Penny

Chair: Human Research Ethics Committee (Medical)

Copy – HREC (Medical) Secretariat

Research Office Secretariat: Faculty of Health Sciences, Phillip Tobias Building, 3rd Floor, Office 301, 29 Princess of Wales Terrace, Parktown, 2193 Tel +27 (0)11-717-1252 /1234/2656/2700 Private Bag 3, Wits 2050, email: zanele.ndlovu@wits.ac.za Office email: hrec-medical.researchoffice@wits.ac.zaWebsite:

Appendix C: Turnitin Report