

## 'No one may be refused emergency medical treatment' – ethical dilemmas in South African emergency medicine

Efraim Kramer, MB BCH, BSc (Hons) Aerospace Med, FCEM (SA), Dip PEC (SA)

Division of Emergency Medicine, Faculty of Health Sciences, University of the Witwatersrand

Enshrined in section 27(3) of the Constitution of South Africa is the right that 'no one may be refused emergency medical treatment'. While this universal human right is altruistic in its simplistic meaning and appears to be in tune with the requirement of freedom, equality and dignity for all in South Africa, in-depth analysis reveals ethical concerns. The definition of a medical emergency, although present on the statute books, recently seems to have been revised by the Constitutional Court, which may have practical ramifications for patients in life-threatening situations. Additionally, there is no definition of what constitutes basic emergency medical treatment, and the author has ventured to resolve this glaring deficiency. The Department of Health's introduction of a hierarchy of health services in South Africa to increase efficiency in the use of scarce health care resources nationally, with emergency medical treatment a notable exclusion, has presented ethical issues concerning patient redirection and transfer from health care establishments. Similarly, redirection and transfer of financially disadvantaged emergency medical patients from private health care establishments present major ethical concerns. It is incumbent upon all health care providers to render basic medical treatment without fear, favour or undue financial demand. The Constitutional Court needs to ensure that it does not excessively limit section 27(3) from an initial absolute provision to one dominated by progressive realisation that potentially may prohibit every individual in South Africa receiving basic emergency treatment when required.

The Constitution of South Africa<sup>1</sup> was approved by the Constitutional Court on 4 December 1996 and put into effect on 4 February 1997. Enshrined in section 27(3) of the Bill of Rights is the right that 'no one may be refused emergency medical treatment'. While this universal human right is seemingly altruistic and innocent in its simplistic meaning, which appears on the surface to be in tune with the Constitution's requirement of freedom, equality and dignity for all in South Africa, in-depth analysis reveals potential and actual ethical concerns. Similarly, the preamble to the National Health Act<sup>2</sup> states:

'Recognising –

- the socio-economic injustices, imbalances and inequities of health services of the past;
- the need to heal the divisions of the past and to establish a society based on democratic values, social justice and fundamental human rights;
- the need to improve the quality of life of all citizens and to free the potential of each person;

Bearing in mind that –

- section 27(3) of the Constitution provides that no one may be refused emergency medical treatment.'

In order to fully appreciate what is intended by section 27(3) of the Constitution, it is essential that the statement be fully dissected into its constituent parts. This will provide a clear understanding regarding the definition and meaning of a medical emergency and the basic tenets of emergency medical treatment.

### The definition of a medical emergency

There is currently no internationally accepted definition of a medical emergency, owing to the multitude of factors that must be

taken into account.\* A current South African definition of a medical emergency can be found in the Medical Schemes Act 1998 (Act No. 131 of 1998):<sup>3</sup> 'the 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'. Although fairly comprehensive, the Constitutional Court in *Thiagraj Soobramoney versus Minister of Health (Kwazulu-Natal)*<sup>4</sup> redefined the concept 'medical emergency' due to the appellant, Mr Soobramoney, basing part of his claim on section 27(3) of the Constitution. This provides that 'no one may be refused emergency medical treatment'. Justice Madala in his judgment, concurring with Justice Chaskalson, defined section 27(3), and hence a medical emergency, as a 'dramatic, sudden situation or event which is of a passing nature in terms of time. There is some suddenness and at times even an element of unexpectedness in the concept "emergency medical treatment"'. This definition, which appears in deliberations without references to any peer-reviewed medical source, may pose particular difficulties in the South African context. As an example, a known asthmatic patient may develop breathing problems which may or may not be related to the asthma and which the patient may initially treat at home, as medically recommended, with medication that has been prescribed. The breathing problem may not resolve and owing to financial, logistical transport or personal domestic issues, the patient may not present to an emergency department for a number of days. In the interim, the original breathing problem may progressively deteriorate until eventually the patient has no option but to seek medical attention. This asthma attack may in fact be an allergic-type incident which may be seasonally anticipated, but which may henceforth constitutionally NOT be defined as a medical emergency, because of the lack of a dramatic, sudden event which was unexpected. Many acute life-threatening medical emergencies involve acute exacerbations or complications of already diagnosed, and in some instances undiagnosed, chronic illnesses,

many of which may present to the emergency department and all of which require emergency medical treatment. Likewise, such an emergency may involve a patient who presents to the emergency department of a health establishment, appearing wasted, malnourished, dehydrated, weak and immunocompromised with chronic diarrhoea, seeking medical assistance, and who by 'constitutional' definition may equally not be defined as a medical emergency. This patient, in fact, is a medical emergency, and the presentation is quite common in South Africa at present with the HIV/AIDS pandemic that exists. Therefore, although the honourable justices may not be entirely incorrect in their use of *acuity of onset* in their definition of a medical emergency, their definition may have major legal implications in Common Law, namely that there may be significant numbers of patients with emergency medical conditions, severe enough to seek professional medical assistance, who may be excluded from urgent care, as their presenting condition may not have been sudden, dramatic, unexpected or catastrophic. It therefore mandates the medical fraternity, not the legal profession, to consider and redefine what medically constitutes an appropriate definition of a medical emergency in modern-day South Africa for purposes of section 27(3). This is fundamental in order to prevent *'the socio-economic injustices, imbalances and inequities of health services of the past'*. It would be currently be more appropriate and safer to consider the definition of the Medical Schemes Act 1998 than that of the Constitutional Court in the Soobramoney case.

## The definition of emergency medical treatment

Section 2(5) of the National Health Act of 2003 states that 'A health care provider, health worker or health care establishment may not refuse a person emergency medical treatment.' This would indicate that any patient who required assistance in a medical emergency could present themselves to any health care establishment in South Africa, where emergency medical treatment could not be refused and hence would have to be instituted. Astonishingly, the Constitution of 1996, the National Health Act of 2003, the Health Professions Act of 1974,<sup>5</sup> the Health Professions Amendment Act of 2007,<sup>6</sup> the Nursing Act of 1978,<sup>7</sup> the Department of Health's Ethical Rules of Conduct<sup>8</sup> and the Department of Health's Patients' Rights Charter<sup>9</sup> are collectively mute on defining the basic practical scope of emergency medical treatment that can be expected to be provided when any individual presents to a health care provider or health care establishment for emergency medical assistance. This glaring deficiency has resulted in, and at times may even have promoted, the redirection of emergency medical patients away from health care establishments of initial presentation to other health care establishments in the area, often without their receiving basic emergency care and ostensibly under the guise of the well-intentioned regulations relating to the Department of Health's introduction of a hierarchy of health services in South Africa. This hierarchy was introduced in order to increase efficiency in the use of the scarce health care resources available nationally. A structure was introduced whereby all patients making use of the public health care system would only be able to access higher specialised levels of care after an initial medical assessment and onward referral by appointment. The recommended exception to this model was a patient experiencing a medical emergency.<sup>10</sup>

There are currently four levels of public hospitals in South Africa: district (primary or level 1), regional (secondary or level 2), tertiary (level 3) and quaternary (national central) hospitals. Each successive level has access to a greater degree of specialist health care and its required resources. The only exception to this hierarchy of care and categorisation of hospitals is emergency medicine, which, if available in any level of hospital, must be in a position to treat and stabilise, resources permitting, any emergency medical patient who presents through its doors. It was never intended, and must be regarded as blatantly unethical and a serious breach of the Constitution, for any patient who presents to an emergency (casualty) department of any health care establishment (hospital) to be turned away and redirected to another health care establishment, without initially receiving basic medical treatment. This situation may arise when the patient's medical emergency is not classified as falling within the official level of care designated for that particular health care establishment. It has therefore unfortunately become standard policy in a number of tertiary/quaternary health care establishments with fully operational emergency departments to triage all patients presenting through their doors, and redirect those classified as inappropriate level 1 or 2 medical emergencies to a more appropriate level 1 or 2 health care establishment nearby. This may occur without initial treatment, transport or an accompanying medical attendant and may result in patients having to travel from one health care establishment to another, constantly being redirected, until eventually due to persistence, determination or deterioration they are finally admitted for medical stabilisation and care.

Equally, an emergency patient presenting at a private health care establishment who is unable to or incapable of paying for necessary emergency medical care, or does not have adequate medical aid or insurance cover, may not be redirected to another private or public health care establishment without initial stabilisation. This would essentially mandate that all patients presenting to private health care emergency establishments will be adequately assessed and stabilised and only transferred to another appropriate health care establishment when all the relevant organisational, medical and transport arrangements have been made to the satisfaction of both referring and receiving establishments and health care providers involved. The issue is one of safe, appropriate transfer after treatment, not hazardous irresponsible redirection instead of treatment, for financial reasons,<sup>†</sup> the former well in accordance with sections 27(1) and 27(3) of the Constitution, the latter gross breaches of both sections.

It must be clearly stated that triage in the emergency department in order to categorise the level of medical emergency, so as to ensure that the most critical patients are always seen immediately and the less critical timeously, is an accepted international practice that occurs daily in every emergency department and to which every patient who presents for acute medical care is subjected. It is also acceptable to triage patients who are not medical emergencies at all, but are merely unwell and whose condition does not warrant attendance at an emergency department. These patients are more appropriately managed by a family practitioner or primary health care clinic, and any attendance at an emergency department is inappropriate. However, it is not acceptable to triage emergency patients and redirect them away from any health care establishment without initial stabilisation and appropriate analgesia. For a registered health care provider to do so is to counter the need to redress the *'socio-economic injustices, imbalances and inequities of health services of the past'*.

It is therefore mandatory that section 27(3) of the Constitution, establishing emergency medical treatment as a basic right, be practically defined in order to leave no room for error or misinterpretation. I would define emergency medical treatment as the provision of, as a minimum, basic emergency medical care, by professional health care providers, to any individual/s presenting to the emergency department of a registered health care establishment or provided to any individual/s on the scene of a medical emergency by health care providers, of a medical condition which may actually or potentially threaten the life, limb or organ function of the person, such that the following assistance shall be attempted, in all patients, where medically required, in a safe, caring, compassionate, competent and communicative manner:<sup>‡</sup>

- attempted provision and protection of a patent airway
- attempted provision of effective ventilation medically, manually or mechanically
- attempted control of external bleeding
- attempted relief of intolerable, unacceptable pain
- urgent attention and appropriate medical intervention in medical conditions in which time is critical to prevent deterioration – these may include, but not be limited to, acute hypoglycaemia, stroke, acute coronary conditions, active labour or severe sepsis.

The above definition, which it is hoped will be adapted and adopted by eventual consensus, may prevent any health care provider in any health care establishment from refusing emergency medical treatment or unacceptably redirecting emergency patients until they are adequately assessed, stabilised and appropriately referred.

## ‘No one may be refused’ or Everyone shall receive’?

The Constitution of South Africa is a positive document that engenders hope for the future and a break from the negativity of the past. The provision of section 27(3) as stated is absolute. It does not state that it is subject to available resources or that only those individuals who are healthy enough to make use of it have this right.<sup>11</sup> However, as can be deduced from *Soobramoney v Minister of Health*, the Constitutional Court argued that section 27(3) cannot be practically enshrined as an absolute right but is subject to the provisions of section 27(2), which states that the ‘state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights’. Although section 27(2) is primarily referring to the rights in section 27(1), the Constitutional Court has included section 27(3) in its ambit. It appears therefore that section 27(3), like many other rights, is not guaranteed or absolute and may need to be limited if necessary. This may be one reason why section 27(3) is espoused in the negative. The concept of progressive realisation of adequate resources is a necessary requirement to practically impart the rights of the Constitution in a systematic manner in South Africa as a developing country. However, it must be argued that the provision of immediate, basic emergency treatment at any health care establishment to any individual in South Africa experiencing a medical emergency, cannot realistically form part of any nation’s progressive realisation policy of progress. Such treatment requires little more than basic medical emergency training of

health care providers and health care workers, using basic equipment, all of which should be nationally available in the emergency departments of all health care establishments. In South Africa, emergency medicine, recognised as a principal medical specialty as recently as December 2004,<sup>12</sup> is based on the need to urgently assess and treat acute medical emergencies, of whatever nature, severity and in whatever location and circumstances, inside and outside of a health care establishment, whatever the circumstance may command. It therefore mandates that those trained in emergency medicine, of whatever qualification and experience, should be able to function effectively and efficiently in saving lives under acute threat, even with minimal equipment, if such resources are scarce or unavailable. There is no doubt that with progressive realisation, the greater the availability of resources, the higher the level of emergency medical care that will be provided. However, the occasion should never occur in South Africa that basic emergency treatment cannot be administered to a life under threat, due to lack of basic knowledge or resources. An appropriate case in point internationally in the Supreme Court of India<sup>13</sup> is the case of *Mazdoor Samity versus State of West Bengal*. The plaintiff, who fell off a moving train with resultant serious head injuries, was taken to the nearest, most appropriate emergency department in a government hospital after initial basic stabilisation at a primary health clinic. He was denied access to the emergency department due to unavailability of beds in the hospital. The court ruled that the State was bound by its constitutional obligation to ‘the right of life of every person and preservation of life being of paramount importance. The government hospitals and the medical officers in them are duty bound in this respect ... that obligation on the state stands irrespective of constraints in financial resources.’ It is therefore the State’s responsibility to ensure that wherever a health care establishment has an emergency department, whether public or private, the attending health care providers are adequately trained and basically equipped to manage any individual who presents for emergency medical assistance. Such immediate assessment and stabilisation must be undertaken before the patient is either admitted to the health care establishment or appropriately and safely transferred to another health care establishment which may be more suitable due to greater resources of care. Unfortunately, the daily practice currently occurring in South Africa of multiple patients being denied access to emergency departments, due to a host of ill-conceived reasons, such as shortages of hospital beds, results in emergency ambulances being redirected from hospital to hospital until permission can eventually be obtained to deliver the patient to basic emergency medical care. This practice is nothing other than a denial of the right not to be refused emergency medical treatment.

## Conclusion

Section 27(3) of the Constitution, which states that no individual may be refused emergency medical treatment in South Africa, is a universal and absolute right. For this reason, it was clearly placed after section 27(1), which details health care access, and section 27(2) which delineates progressive realisation. It is fundamental that this logical sequencing of the sections relating to health care are not interpreted haphazardly, as was done unintentionally in *Soobramoney versus Minister of Health* with potential ethical and practical dilemmas for emergency medicine. Progressive realisation is a necessary practical evil that exists in all developing countries and will include health care provision, just as it impacts

on many other rights. However, fundamentally emergency medical treatment in an acute life-threatening medical emergency is a basic absolute right, which is and must remain the exception to the realisation of any progressive political, economic or legal development policy. To countenance otherwise is to demean the value of life and to endorse the developed world's technological secularisation where the healthy and the strong are valued more than the ill and ailing.

Wherever in the world one may find oneself when confronted with a medical emergency that potentially or actually threatens the life or limb of an individual, the prevailing health care system is morally obliged to render some form of basic medical treatment without fear, favour or undue financial demand. South African emergency medicine health care providers and members of allied disciplines are recognised as among the most experienced and competent medical practitioners in the world and it is our duty, bound by the Constitution, to ensure that every individual in South Africa receives the most appropriate and applicable emergency care when required, and to undertake this task by constantly striving to treat, teach and train wherever and whenever possible. Section 27(3) of the Constitution is a right that must be guaranteed, even if at a basic level, without justification, defence or limitation.

## References

1. The Constitution of the Republic of South Africa (Act No. 108 of 1996). <http://www.info.gov.za/documents/acts/1996.htm> (accessed 23 March 2008).
2. National Health Act (Act No. 61 of 2003). <http://www.info.gov.za/documents/acts/2003.htm> (accessed 23 March 2008).
3. Medical Schemes Act (Act No. 131 of 1998). <http://www.info.gov.za/gazette/acts/1998/a131-98.pdf> (accessed 23 March 2008).
4. *Thiagraj Soobramoney versus Minister of Health (Kwazulu-Natal)* 1997 (12) BCLR 1696 (CC). [http://www.imsa.org.za/files/Library/Health%20Case%20Law%20\(9\)/Cases%20on%20Health%20care%20issues/Soobramoney%20case.pdf](http://www.imsa.org.za/files/Library/Health%20Case%20Law%20(9)/Cases%20on%20Health%20care%20issues/Soobramoney%20case.pdf) (accessed 23 March 2008).
5. Health Professions Act, 1974 (Act No 56 of 1974). <http://www.info.gov.za/documents/acts/2003.htm> (accessed 23 March 2008).
6. Health Professions Amendment Act (No 29 of 2007). <http://www.info.gov.za/gazette/acts/2007/a29-07.pdf> (accessed 23 March 2008).
7. Nursing Act, 1978 (Act No 50 of 1978). <http://www.info.gov.za/documents/acts/2003.htm> (accessed 23 March 2008).
8. Ethical Rules of Conduct for Practitioners registered under the Health Professions Act, 1974. *Government Gazette* No. R 717, 4 August 2006.
9. South African Department of Health: Patients' Rights Charter. <http://www.doh.gov.za/docs/legislation/patientsright/chartere.html> (accessed 23 March 2008).
10. Cullinan K. Health Services in South Africa: A basic introduction. 2006. Health e-News Services. [www.health-e.org.za/uploaded/cb1f388f3b351708d915c12cfb4fc3cf.pdf](http://www.health-e.org.za/uploaded/cb1f388f3b351708d915c12cfb4fc3cf.pdf) (accessed 7 November 2008).
11. Van der Walt J. 2005. *Law and Sacrifice: Towards a Post-Apartheid Theory of Law* [e-book]. Wits University Press. [http://books.google.co.za/books?id=jrQxBbjoX5sC&pg=PT6&source=gbs\\_toc\\_r&cad=0\\_0&sig=imBgzyARu8PDuIM6fndq8bmOFlw#PPT6,M1](http://books.google.co.za/books?id=jrQxBbjoX5sC&pg=PT6&source=gbs_toc_r&cad=0_0&sig=imBgzyARu8PDuIM6fndq8bmOFlw#PPT6,M1) (accessed 1 May 2008).
12. *Government Gazette*, No. R 1457, 13 December 2004.
13. *Paschim Banga khet Mazdoor Samity versus State of West Bengal* 1996 SOL Case 169 (Supreme Court of India). <http://www.communitylawcentre.org.za/Socio-Economic-Rights/case-reviews1/foreign-cases/paschim-banga-khet-mazdoor-samity-versus-state-of-west-bengal-1996-sol-case-no-169-supreme-court-of-india/> (accessed 23 March 2008).