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HPCSA
Health Professions Council of South Africa

Emergency Care NEWS

Newsletter for Emergency Care Professional Board

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CHAIRPERSON'S NOTE

The Minister of Health appointed new Professional Boards in November 2020 for the period ending 2025. The members of the Professional Board for Emergency Care are as follows:

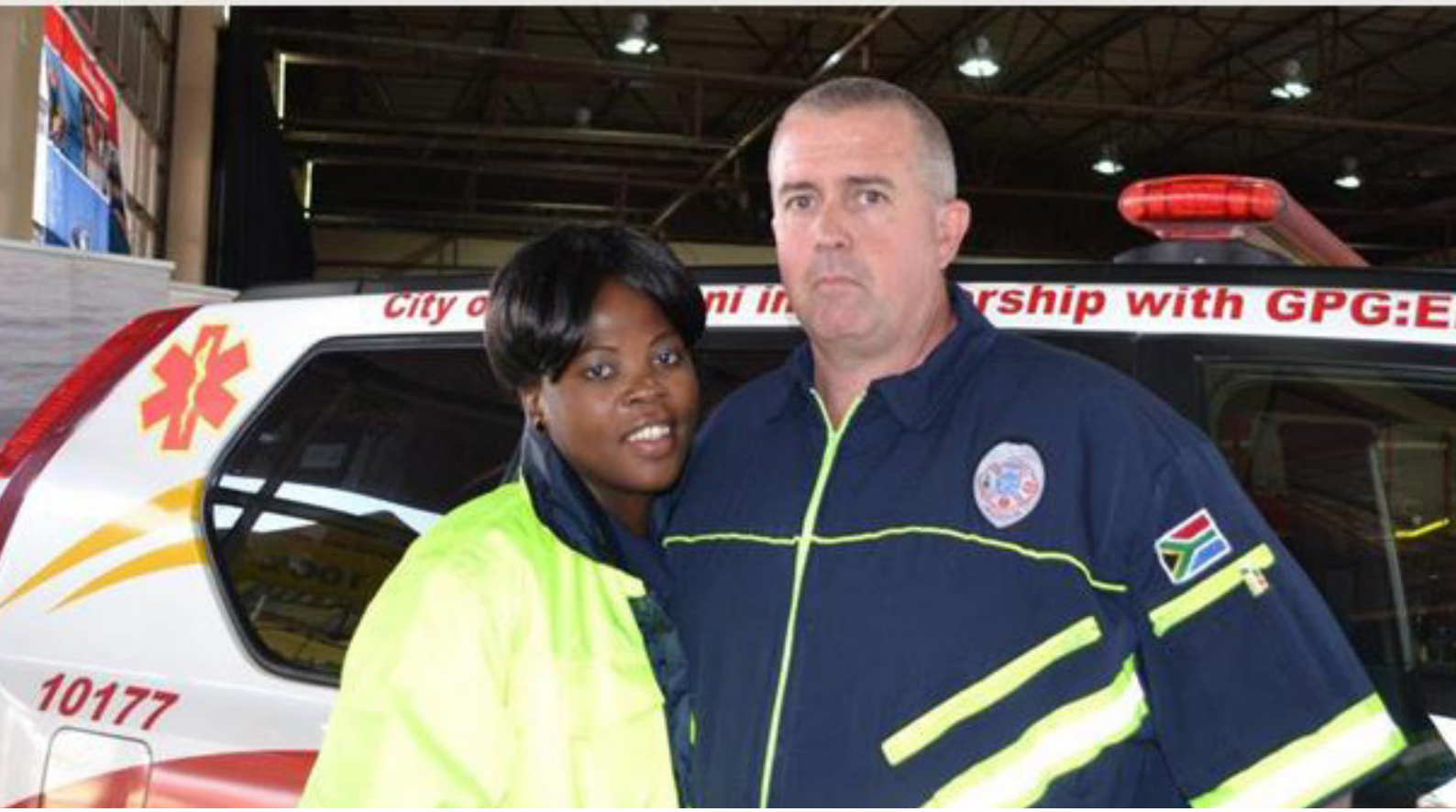
Dr Simpiwe Sobuwa (Chairperson)
Mr Sidney Dywilli (Vice- Chairperson)
Mr Ahmed Bham
Mr Benjamin Simon van Nugteren
Mr Johannes Mohanoe Mokoena
Mr Lloyd Christopher
Dr Mzayifani Sibanda
Ms Ziphora Mmabatho Ramaila
Mr Theodore Schilder
Mr Ashley Grant Alcock
Mr Ashok Kumar Munilal
Ms Bridget Nikiwe Zungu
Ms Tracy Whittaker
Mr Sipho Sidney Towa
Ms Keorapetse Daphney Qonde
Ms Sindisiwe Precious Masondo
Mr Tshepiso Lesego Kgokong
Ms Anita Ngxumza
Ms Mahlatse Vivy Molokoane
Mr Ketso Lucky Tsekeli

BOARD STRATEGIC OVERVIEW 2020-2025

The Professional Board for Emergency Care has outlined six main strategic goals to pursue during its term (Financial Years 202122 to 2025/26). The first strategic goal refers to optimised interdepartmental cooperation for clinical guidelines. This strategy aims to develop a stakeholder turnround plan, that promotes revision and updating of the clinical guidelines. This will be achieved by implementing a functional interdepartmental forum, to monitor and evaluate clinical guidelines. The efficacy of this forum will be assessed annually. The second strategic goal refers to an approved roadmap for qualifications, roles, and objectives for emergency care vision 2030. This will provide an outline of the minimum standards for postgraduate qualifications required to register with the Board and ensure adherence to these requirements. To achieve this, the Board will set-up a functional task-team to realise EMS vision 2030; develop postgraduate minimum standards for qualifications registerable in Emergency Care by 2025 to enable specialisation, which includes stakeholder engagement and promulgation of minimum standards for postgraduate qualifications; align the scope of the profession and related scopes of practice to the EMS vision 2030, and lastly merge various Emergency Care registration categories by 2025. The third strategic goal refers to effective and efficient Preliminary Committee and Professional Conduct processes. This strategy will attempt to address current concerns related to the prolonged duration and elevated costs of such processes. To achieve this strategy, the Board intends to provide a reviewed Cost Structure for running Professional Conduct Enquiry processes; implement a "Virtual Platform" as a formal Professional Conduct Enquiry processes channel, and lastly, use the Ombudsman to resolve and reduce complaints going into the Professional Conduct by 2025 by obtaining approval for regulations enabling Ombudsman to finalise on matters. The fourth strategic goal refers to the improved functioning of the Professional Board through the development of regulations, guidelines, rules and policies. The Board as a regulator and part of Council must

be fully conversant with regulatory science if it need the impact of the regulations to be consistent in delivering positive Health Systems outcomes. Secondly, the Board has a duty to ensure that it is properly governed in line with the appropriate government regulations. Existing regulations will be validated, and where necessary, non-existing regulations will be developed. This will be achieved through the review and/or development of regulations, and through the review and/or development of relevant guidelines and rules. The fifth strategic goal refers to capacitated members of the PBEMB effectively executing their fiduciary responsibilities and ensuring proper functioning of the Board. Implementation of this strategy is key to ensure all Board members are appropriately capacitated to execute their regulatory and governance roles to allow for efficient operation and accountability from the Board against the mandate and fiduciary responsibilities. The Board aims to achieve this strategy by providing adequate training to the Board members to execute their fiduciary responsibilities, as well as increase the number of resolved cases at Prelim Committee level, through implementing capacity building workshops and improving case preparation processes. The last strategic goal refers to improved relationships between Professional Board for Emergency Care and all relevant stakeholders by the end of the term (2025). This strategy is aimed at improving the poor relationship between the HPSCA, the Board and all relevant stakeholders to increase the number of stakeholders becoming HPCSA and EMB ambassadors. Therefore, the Board has aligned to the HPCSA wide movement to rebuild stakeholder relationship practices to create long-term, mutually beneficial relationships. The Board aims to achieve this by implementing annual stakeholder engagement strategy initiatives and evaluating the impact of the Stakeholder Engagement Strategy every two years.

Chairperson of the Professional Board for Emergency Care Professions
Dr Simpiwe Sobuwa



PATIENT RIGHTS IN AN EMERGENCY CARE SITUATION

Section 27 of the Constitution of the Republic of South Africa guarantees the right to have access to healthcare services as a socioeconomic right and stipulates that no one may be refused emergency medical treatment. Section 5 of the National Health Act, 61 of 2003 imposes a duty similar to that in the Constitution, stipulating that a healthcare provider, health care worker or healthcare institution may not refuse any person emergency medical treatment. Emergency care providers are healthcare providers trained to attend to these emergencies and provide emergency medical care. These emergency care providers may work for either public or private Emergency Medical Services (EMSs).

The right not to be refused emergency medical care applies to treatment sought by both public and private healthcare providers. It should, however, be noted that free emergency medical treatment is not guaranteed, and private healthcare providers and/or healthcare institutions may, after providing such emergency treatment, attempt to recover payment for the services provided.

The private sector payment rates for prehospital patient care are primarily based on the level of care provided, be it basic, intermediate or advanced life support level. The Professional Board for Emergency Care (PBEC) has dealt with instances where emergency care providers have been accused of prioritising patients who have been identified to have some form of medical aid/ insurance or alternative form of financial cover for emergency care treatment. In these instances, patients without medical aid/insurance may be ignored by the EMS providers and left behind on the scene for alternative EMS providers, who may or may not have been dispatched to the incident, to provide care. These practices are unethical and unlawful. They violate professional codes of ethics and constitute a direct contravention of the provisions of Section 27(3) of the Constitution and Section 5 of the National Health Act.

Instances may occur where patients seen by certain EMS providers may be overtreated to generate additional revenue based on the level of care provided. For example, intravenous access may be implanted unnecessarily so that service providers can claim Intermediate Life Support rates. Inappropriate administration of medications where these may not be indicated has also been highlighted. This is particularly relevant with regards to administration of analgesia. The administration of certain medications therefore then allows EMS providers to charge patients for Advanced Life Support interventions. Finally, although under disaster situations it may be appropriate to transport multiple patients in an ambulance, under normal conditions transporting multiple patients in an ambulance to generate additional revenue is not appropriate. These practices too constitute unethical practice and a violation of patient rights. Registered persons performing such acts will be held liable for these activities.

While an ambulance may have been called out or strategically positioned/prepositioned at “accident hotspots” to be the first ambulance on-scene and increase the number of patients eligible for transport, every patient has a right to refuse treatment and choose to be treated by a particular EMS provider. In other words, no one has the right to engage with a patient without the patient’s consent, let alone start performing medical interventions in the guise of providing help.

In terms of Section 6 of the National Health Act, 61 of 2003, everyone has the right to informed consent and to appreciate the risks and benefits associated with the relevant treatment. Patients have autonomy over their own bodies and the right to participate in decision making on matters affecting their own health. This includes any financial implications related to treatment. No emergency treatment may be refused based on an individual’s ability to pay for the services. When an unconscious patient needs emergency medical treatment, and there is no family member or guardian available to consent, consent may be implied provided that treatment is guided by what is necessary to preserve the life or health of the patient.

Every patient has a right to be treated by a clearly identifiable, named healthcare provider. This is to allow for routine interaction as well as to allow for follow-up on a practitioner’s conduct in the case of any queries arising. All emergency care personnel are registered with the HPCSA and, in the case of violation of a patient’s right/s, a complaint against the health care provider can and should be lodged against the relevant provider.

REFERENCES

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THE ROLE OF THE HEALTH COMMITTEE

The mandate of the Health Professions Council of South Africa (HPCSA) in protecting the public and guiding the professions includes ensuring that healthcare practitioners are fit to practise their profession. As such, the Health Committee of the Boards is established in terms of Section 15(5) of the Health Professions Act, 56 of 1974 (The Act) to regulate and/or advise healthcare practitioners who may be impaired. Impairment means a mental or physical condition or the abuse of or dependence on chemical substances, which affects the competence, attitude, judgment or performance of a person registered in terms of the Act.

Allegations of impairment of healthcare practitioner may be reported to the HPCSA by anyone, including members of the public as well as own or fellow healthcare practitioners. Healthcare practitioners includes registered students and interns. Any reported case is referred to the Health Committee for assessments (formal or informal), mostly based on medical reports in order to make considered findings. The healthcare practitioner is, of course, always notified of the complaint and is requested to undergo relevant assessments to ensure that the committee is empowered to make a resolution on the case. The assessments are only conducted by the qualified specialist appointed by the Health Committee or self-appointed healthcare practitioner.

After all the processes and assessments are conducted, the Health Committee makes determination if impairment exists or not. The healthcare practitioner can only be declared impaired in terms of Section 51 of the Act. Note that such declaration may be followed by conditions of practice, such as limitation of practice, registration restrictions etc, depending on the specific case.
The committee recommends and provides oversight of the implementation of a treatment and/or rehabilitation programme and frequently reviews the status of the healthcare practitioner over a duration of time, typically for at least three

(3) years. The healthcare practitioner who is under the management of the committee provides frequent reports to ensure that the committee can evaluate progress. Typically the reporting frequency start with quarterly, then followed by bi-annual progress reports , annual reports, followed by an exit interview depending on the progress made in achieving rehabilitation.

It is in the best interest of the affected healthcare practitioner to co-operate with the process and instructions of the Health Committee, not only for their rehabilitation, but in ensuring that the public is protected from potentially harmful practice. In the absence of co-operation healthcare practitioners the Health Committee may appoint an investigation committee on an ad hoc basis to undertake formal investigations and, if required, may impose conditions of registration or practice.

The committee also considers applications by impaired healthcare practitioners to have their conditions of registration or practice amended or revoked.

What is important is that the Health Committee is a non-punitive structure established to manage treatment compliance by the healthcare practitioners. Declaration of impairment does not necessarily mean suspension, the healthcare practitioner can still practice after being declared an impaired practitioner. The decision to suspend a healthcare practitioner is solely based on evidence available, mostly from medical reports as provided by the treating practitioner.

The current Health Committee of the Professional Boards consist of elven (11) members representing each Professional Board. The committee also co-opt one (1) Psychiatrist from Medical and Dental Board. When fully constituted, is always composed of the following professions:

- One Clinical Psychologist;
- One Occupational Therapist;
- One Psychiatrist

Chairperson is elected amongst the Professional Boards represented.

To contact the Health Committee or to report an alleged impairment kindly contact us at: email healthcommittee@hpcsa.co.za or telephone 012 3383963.

VACCINATIONS AND ANTIBODY TESTING DURING COVID-19

The Professional Board for Emergency Care (PBEC) wishes to communicate the following in relation to queries related to the Point of Care (POC) antibody testing and vaccine administration for the Severe Acute Respiratory Syndrome Coronavirus – 2 (SARS-CoV-2) by registered emergency care persons:

- The Board acknowledges that various POC antibody testing options are currently available for widespread use. These POC antibody tests are available to members of the public without healthcare practitioner's referral.

- In the context of providing emergency care, the Board does not recommend the routine use of SARS-CoV-2 POC testing when determining the need to provide emergency care.

- From an emergency care perspective, SARS-CoV-2 POC testing should only be performed where a clear indication exists. This testing must occur in consultation with a healthcare practitioner who will be overseeing, teleconsulting or receiving the patient from an emergency care environment.

- In relation to SARS-CoV-2 vaccine administration, the Board does not support the administration of vaccinations in an isolated, sporadic and uncoordinated fashion.

- Where applicable, and through the coordination of the relevant healthcare system responsible for vaccination rollout, emergency care registered persons who are able to administer medications via the appropriate route may do so provided they have had the requisite vaccination administration training and the place of vaccine administration (venue) is considered a vaccination centre as designated by the relevant health authority.

REGISTRATION (HPCSA) REQUIREMENTS FOR FIREFIGHTERS

The Board often get inundated with enquiries on whether firefighter should register with the HPCSA or not.

It should be noted that, in terms of the Health Professions Act, 56 of 1974 (as amended), any persons/ practitioners involved in the clinical care of patients in an emergency care environment, registration with the Health Professions Council of South Africa is mandatory.

Furthermore, emergency and support services, as well as the individual persons concerned should take reasonable measures to ensure that those who routinely respond to incidents and callouts involving ill and/ or injured patients are duly registered with the HPCSA in the relevant registration category and appropriately equipped to render that level of care.

SOCIAL MEDIA AND THE USE OF TECHNOLOGY IN EMERGENCY CARE

Patients have a right to dignity, privacy and confidentiality whilst receiving emergency care. This is enshrined in the Constitution of the Republic of South Africa and must always be respected. Emergency Care Providers are reminded that the taking of photographs and/or recording of video and/or audio footage and/or subsequent dissemination (either via personal communication or social media) of incidents and clinical interactions between Emergency Care Providers and patients has implications regarding the right to patient practitioner privacy and confidentiality.

Whilst the taking of photos and the recording (audio or video) of incidents and patient care may have a role to play in clinical governance, teaching, learning and research, all such activities need to be part of a documented project that is ethically approved with informed patient consent.

Ethical approval for such activities shall come from a registered Ethics Committee. This is to ensure that the production, access to, distribution and storage of audio/visual materials is appropriately and confidentially managed. Audio/visual recording of the mobilisation and response to an incident may be recorded provided that neither patient nor clinical activities are captured, recorded, or distributed.

SHOULD EMERGENCY CARE PERSONNEL BE CARRYING FIREARMS?

Emergency Medical Services workers have marched against ongoing attacks on emergency care personnel in recent times to raise public awareness.

These workers continue to be at the brunt of robberies and attacks, which seem to be on the increase in some areas. Judging by media reports on recent incidents, it appears that the attacks may becoming more violent and increasingly involve the use of firearms.

A kneejerk response to these trends would be to call for emergency care personnel to carry firearms, as a labour union did a couple of years back. Fight fire with fire, as it were.

However, there is a growing body of evidence internationally showing that increased carrying of guns in public is associated with increased gun violence. Branas et al. (2009) conducted a study of assault victims in Philadelphia, USA, from 2003 to 2006. They found that individuals in possession of a gun were 4.46 times more likely to be shot in an assault than those not in possession.

A 2017 meta-analysis by Benjamin et al. noted a landmark 1967 study which showed that simply seeing a gun can increase aggression (the so-called "weapons effect"). They reviewed 78 independent studies since then, involving 7 668 participants. The results confirmed the weapons effect and showed that "merely seeing a weapon can increase aggressive thoughts, hostile appraisals and aggressive behaviour".

Extrapolating these findings to the current context, the evidence suggests that arming emergency care personnel in South Africa is likely to actually increase the risk of violent attacks on emergency care personnel, also placing unarmed personnel, patients and bystanders at increased risk.

This observation has important practical and policy implications. While there is no nationally applicable law or regulation specifically governing the carrying of firearms by emergency care personnel, emergency service providers have significant discretion in the development of policies applicable to their employees.

In the development of these policies, employers need to be cognisant of the following:

Firstly, the ethical duty of non-maleficence requires healthcare practitioners not to harm or act against the best interests of patients. Practitioners need to be aware that if their carrying or handling of a

firearms place patients at an increased risk, they are acting in breach of this principle.

Secondly, in terms of Section 8(1) of the Occupational Health and Safety Act (OHSA), employers have a duty to provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of its employees. The literature as discussed above suggests that allowing emergency care employees to carry firearms is likely in fact to increase, rather than decrease, risk to the health of employees in their workplace. The workplace risks presented by firearms are especially acute in the confined space of an ambulance, especially when carrying potentially aggressive patients and escorts.

Thirdly, employers have a duty in terms of OHSA to take such steps as may be reasonably practicable to eliminate or mitigate any hazard or potential hazard to the safety or health of its employees. To the extent that employers do in fact allow their employees to carry weapons, employers are obliged to put in place measures to mitigate the hazard caused by the firearms. This would include, but not be limited to, appropriate training of employees in use of firearms and in conflict de-escalation techniques.

Fourthly, if emergency care personnel carry firearms on their persons into hospitals, airports and other gun-free zones, they may be breaking the law and placing themselves at risk of prosecution.
Fifthly, in the event of accidental or otherwise negligent discharge of a firearm by a practitioner causing injury or death to a patient, bystander or colleague, not only would the practitioner carry resultant liability for that injury or death, but the employer would almost certainly also be vicariously liable.

Ultimately, guns cannot protect emergency care personnel, but communities can. The respect and goodwill of all sectors of the community, even criminals, towards emergency care personnel depends on these personnel to be perceived as non-threatening and neutral care givers who act in all times in the best interests of patients irrespective of who those patients are. There is a very real risk that the arming of emergency care personnel in South Africa is squandering this protection.

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UPDATE- GOVERNMENT GAZETTE NO. 45176 OF SEPTEMBER 2021

The Professional Board for Emergency Care (PBEC) notes Government Gazette 45176 of 17 September 2021 where the Minister of Health, in term of Section 22A(2) of the Medicines and Related Substances Act of 1965 (Act No 101 of 1965) made and updated the Schedules.

The PBEC carefully considered the updated Schedule and advises persons registered with the PBEC of the following:

a) Refer to ANNEXURE A – list of capabilities and medications April 2022 of this communique with regards to the impact of Government Gazette 45176. This is to be implemented immediately

b) The PBEC is currently engaging relevant stakeholders and requesting review and possible amendment to the Schedule with regards to certain medications as highlighted in ANNEXURE A – list of capabilities and medications April 2022.

c) Ongoing education and training activities are mandatory with regards to those medications currently approved as well as those under review.

d) As previously communicated, where the Government Gazette refers to a specific professional registration category [i.e. Basic Ambulance Assistant (BAA), Ambulance Emergency Assistant (AEA), Paramedic (ANT), Emergency Care Assistant (ECA), Emergency Care Technician (ECT) and Emergency Care Practitioner (ECP)], the utilisation of the medicine applies to all qualifications leading to registration in that specific category. The PBEC is engaging with the relevant stakeholders to have the Government Gazette amended to include all qualifications leading to registration in a particular category.

NATURE OF QUERY	CONTACT
HPCSA Call Centre	(+27) 12 338 9300 info@hpcsa.co.za
All registration related matters	kgomotsom@hpcsa.co.za
Annual fee payments, Practising Cards, Restorations to the register	kgomotsom@hpcsa.co.za
Certified Extracts from the register. Certificates of Status, Verification of Licensure	KgomotsoN@hpcsa.co.za
Applications for Registration (Foreign Qualified)	**Ms Matshidiso Mogole** Matshidisol@hpcsa.co.za
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Scope, ethical, professional practice related and CPD queries	HoD: Professional Practice - **Mr M Mbodi:** Professionalpractice@hpcsa.co.za zamangeman@hpcsa.co.za helenad@hpcsa.co.za
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