Medical Institutions' and their Employees' Obligation to Provide Emergency Medical Treatment for victims of Motor Vehicle Accident in Ethiopia

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1. Introduction

Motor vehicle accident is the largest single cause of death and common cause of hospital admission and life-long disability.[1] According to UN Reports, every year more than 1.3 million people die due to car accident.[2] Among these, 65 percent of deaths involve pedestrians, from which 35 percent are children.[3] Moreover, every year 20-50 million people suffer injury, and often are disabled due to motor vehicle accidents.[4]

In this respect, Ethiopia is categorized among countries that experience a high number of motor vehicle accidents.[5]The number of deaths and injuries due to motor vehicle accident is also consistently escalating.[6] For instance, a study conducted on Addis Ababa City showed that the number of burials due to car

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[1] Tekebash Araya *et al* (2010), 'Road Traffic Accidents in Addis Ababa (2001-2008): Evidence from Burial Surveillance', *Abstracts of Research Findings Presented on the 20th Annual Conference of Ethiopian Public Health Association* (Master Printing Press PLC, Addis Ababa), p. 27.

[2] The UN General Assembly (30 September 2011) A/66/389, Sixty-sixth session Agenda item 12 Global Road Safety Crisis: Improving Global Road Safety, p. 3.

[3] The Second African Road Safety Conference Report (Nov. 09-11, 2011), Addis Ababa, Ethiopia, p. 2.

[4] The UN General Assembly, *supra* note 2.

[5] Tebebe Beshah and Shawndra Hill, 'Mining Road Traffic Accident Data to Improve Safety: Role of Road-related Factors on Accident Severity in Ethiopia', p.2.<http://www.google.com.et/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&ved=0CB0QFjAA&url=http%3A%2F%2Fai-d.org%2Fpdfs%2FBeshah.pdf&ei=x3pAUKmFJYXEswbft4GoDA&usg=AFQjCNG-ADeVFdgdo86dRISzvmMyWE2KhA>, visited on 30 August 2012.

[6] Vehicle Insurance Against Third Party Risks Proclamation No. 799/2013, Federal Negarit Gazeta 19th Year No. 53 ADDIS ABABA 23rd July, 2013 (hereinafter Vehicle Insurance Against Third Party Risks Proclamation), preamble, para. 1.;

accidents is increasing.[7]There was a 4% increase in the number of deaths due to motor vehicle accidents in the City over the past Seven years.[8]This escalation is further evidenced in recent reports. In the year 2003 E.C, the FDRE's Transport Minister reported 2,500 deaths due to car accident, whilst in the year 2005 E.C 3,117 people died due to the same cause.[9] This shows an increase in fatalities within a period of two years that is more than 500. It is for this reason that, countries including Ethiopia come up with a law that intend to ensure a timely and organized response to the effects of car accidents so that the negative impacts of such accidents can be minimized.[10]These efforts particularly focus on the right to get emergency medical treatment for victims of motor vehicle accidents.

This article explicates medical institutions' and their employees' obligation to give emergency medical treatment for victims of motor vehicle accidents. In due course, the article goes through requirements and procedures medical practitioners should follow at times of emergency, and explicate the law that applies to the same. Accordingly, Section I provides a general overview what constitutes emergency medical conditions and treatment. Section II explicates medical procedures that medical institutions and their employees should follow in offering emergency medical treatment. Furthermore, in all sections the

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[7] Tibebessilase Abera (2012), 'Compulsory Motor Vehicle Third Party Liability Insurance in Ethiopia: A Comparative Analysis' (LL.B Thesis, Mekelle University, unpublished) p.1.

[8] Tekebash Araya *et al, supra* note 1.

[9] **ሪፖርተር ጋዜጣ (መጋቢት** 22)፣ **ባለፈው አመት ከሶስት ሺህ በላይ ሰዎች በትራፊክ አደጋ ሞቱ፣ ገጽ** 15።።

[10] M. Kristensen *et al,* Participatory Design in Emergency Medical Service: Designing for Future Practice, p.161. Vehicle Insurance Against Third Party Risks Proclamation, Article 27. In fact, the best approach to alleviate the consequences of motor vehicles is to adopt the preventive approach. Nevertheless, car accidents are inevitable. As a result of this, the Ethiopian government took several measures in order to tackle road safety in a comprehensive manner, such as adopting a law that obliges medical institutions to extend emergency medical treatment for victims of motor vehicle accident. Other measures include adopting a new law on drivers' training and regulation, and issuing motor vehicles technical inspection standards. *See,* A. Thomas (2002), 'The Role of the Motor Insurance Industry in Preventing and Compensating RoadCasualties',p.1,<https://www.google.com.et/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&cad=rja&ved=0CFQQFjAG&url=http%3A%2F%2Fwww.heartsafeam.com%2Ffiles%2FCalifornia_Good_Samaritan_Act.pdf&ei=savsUvycMOGV7Aao0oF4&usg=AFQjCNFRBVcdPW3VmDgcx8uUwQj2l-5Fqg&bvm=bv.60444564,d.bGQ>, visited on 2 January 2014; *see* also Third Party Insurance to Help Lower Ethiopia's High Road-traffic Accident Toll (Nov. 8, 2011), <http://addisababaonline.com/third-party-insurance-to-help-lower-ethiopias-high-road-traffic-accident-toll/>, visited on 22 August 2015.

experience of other countries will be discussed to shed some light on of the law and practice in Ethiopia. In such a way, an attempt is made to highlight the loopholes that are prevalent in the Ethiopian legal system.

2. General overview on Emergency Medical Condition and Treatment

The meaning of the phrase "emergency medical condition and emergency medical treatment" is always central to emergency schemes. This is because emergency medical treatment is primarily there for the benefit of persons under emergency medical condition. Accordingly, this section is devoted to investigate the meaning of emergency medical condition and treatment under the Ethiopian legal system.

In fact, the meaning of emergency medical condition and the obligation to give emergency medical treatment are blurred under the Ethiopian legal system. However, a detailed analysis of the Food, Medicine and Health Administration Control Proclamation and the Vehicle Insurance Against Third Party Risks Proclamation seem to provide a comprehensive definition of the terms.

2.1 The concept of Emergency Medical Condition and Treatment

Emergency refers to a sudden, unforeseen hazardous event that necessitates an immediate response.[11]It refers to a condition that presents a substantial risk of serious harm.[12]It represents a situation that is a result of an accident,[13]and requires a prompt response to save life, property, health and/or environment.[14]In this respect, the sources of emergency can be natural, manmade or technological.[15]This includes terrorist attacks, war, fire and

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[11] *Merriam Webster's Dictionary* (Library of Congress, USA, 2006).

[12] TITLE 31Welfare Welfare Agencies CHAPTER 39. ADULT PROTECTIVE SERVICES, <http://delcode.delaware.gov/title31/c039/index.shtml>, visited on 2 January 2014.

[13] From the perspective of motor vehicles the term "Accident" refers to the happening related to a motor vehicle causing personal injuries or material damages and therefore engages the third party liability of the policy holder. *See* Protocol on the Establishment of a Third Party Motor Vehicle Insurance (Lusaka, 1981) ANNEXE VI-10.

[14] I. Kelman and S. Pooley(eds.) (2004), Disaster Definitions, p.7. available at, www.ilankelman.org/miscellany/DisasterDefinitions.rtf , Last accessed on 26August 2013.

[15] General Assembly 4th Committee, Disaster Relief and Management, p. 1. < http://www.google.com/url?sa=t&rct=j&q=emergency%20can%20be%20either%20natural%2

diseases.[16]Based on the causes of the emergency the response taken towards it may differ. The response in this regard could either be medical and/or humanitarian.

While this is what we mean of emergency, emergency medical condition refers to a sudden and urgent medical state of a person that requires an immediate medical attention.[17] It is a physical and/or psychological state of a living being that requires an immediate clinical or psychiatric treatment in order to minimize the adverse consequences of trauma.[18]However, this does not mean that all medical conditions that require prompt medical attention necessarily qualify as emergency medical conditions. In other words, emergency medical condition only represents a sudden serious medical condition that requires immediate '*stabilization*'.[19]Consequently, in order to say a person is under emergency medical condition the patient must be in a critical state whereby s/he would either die or suffer from serious medical deterioration unless s/he is promptly stabilized. Moreover, in addition to the element of suddenness emergency medical condition assumes that the patient/victim has no opportunity to make arrangements for treatment by the time it encounters the emergency.[20]

On the other hand, the term emergency medical treatment refers to a medical treatment undertaken to mitigate the effects of emergency. It refers to a

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0or%20manmade.&source=web&cd=4&cad=rja&ved=0CEgQFjAD&url=http%3A%2F%2Fmontessorimun.org%2Ffiles%2FFileUpload%2Ffiles%2FBackground%2520Guides%25202013%2FMontessori%25202013%2520SPECPOL%2520Disaster.pdf&ei=EOcpUvj5MIKshQfxkoHQAw&usg=AFQjCNG2KP1IqebRK7VAEnVn0563VYbD5w&bvm=bv.51773540,d.Yms>, visited on 24 June 2013.

[16] U.S Federal Emergency Management Agency, Version 2.0 of Comprehensive Preparedness Guide (CPG)101: Developing and Maintaining Emergency Operations Plans, p. intro-2. Available at www.fema.gov/pdf/about/divisions/npd/CPG_101_V2.pdf

[17] *Thiagraj Soobramoney* v. *Minster of Health* (Kwazulu-Natal), 27th Nov. 1997, Constitutional Court of South Africa (Case CCT 32/97), § 18. (hereinafter *Soobramoney* v. *Minster of Health*)

[18]Managing Emergencies and Traumatic Incidents, p. 10, <www.minedu.govt.nz/~/.../EmergencyManagement/TheGuideSm.pdf> , visited on 28 August 2013.

[19] Law Commission of India (201ST Report) (2006), *Emergency Medical Care to Victims Of accidents and During Emergency Medical Condition and Women Under Labor,* p. 7. On this part, this section restricts the concept of emergency medical condition from the perspective of human beings.

[20] *Soobramoney* v. *Minster of Health*, *Supra* Note 17.

medical treatment offered either to save the life of a patient, or minimize serious deteriorations on the medical state of a patient under emergency medical condition.[21] In this respect, the concept and scope of emergency medical treatment is better explained in *Soobramoney v. Minister of Health* before the Constitutional Court of South Africa[22] as follows;[23]

> *"... emergency medical treatment relates to the particular sense of shock to our notions of human solidarity occasioned by the turning away from hospital of people battered and bleeding or of those who fall victim to sudden and unexpected collapse. It provides reassurance to all members of society that accident and emergency departments will be available to deal with the unforeseeable catastrophes which could befall any person, anywhere and at any time."*

Accordingly, an emergency medical treatment only deals with unforeseeable tragedy that could befall on any person, at any place and at any time.[24] It is concerned with sudden and at times even unexpected medical complications.[25] In this respect, elements of non-foreseeability and imminence are crucial. Its purpose is also limited to stabilizing the patient. In other words, it does not entitle a right to ongoing treatments in case of chronic illnesses.

Consequently, as can be seen from the discussion in the previous paragraphs the concept of emergency medical condition and treatment are inseparable. This is because; emergency medical treatment is necessarily given for a person under emergency medical condition. The meaning given to one necessarily defines the scope and meaning given to the other.

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[21] *Emergency Medical Services*, <http://www.princeton.edu/~achaney/tmve/wiki100k/docs/Emergency_medical_services.html>, visited on 2 January 2014.

[22] Republic of South African Constitution expressly recognizes the right to emergency medical treatment. *See,* Constitution of the Republic of South Africa No. 108 Of 1996 (18th Dec. 1996), § 27(3).

[23] *Soobramoney* v. *Minster of Health*, *supra* note 17, § 51. The Case deals with the interpretation of § 27(3) and § 11of the South African Constitution. These two sections deal with the right to emergency medical treatment and the right to life respectively. In the case the Constitutional Court primarily deal with the issue of "Whether the right to emergency medical treatment include a claim for an ongoing treatment of chronic illnesses that would prolong life?"In conclusion, the Court reached a decision that the right to emergency medical treatment benefits only individuals that necessitate immediate medical treatment for stabilization.

[24] *Soobramoney* v. *Minster of Health*, *supra* note 17, § 51.

[25] *Ibid*, § 38.

Coming to the specific meaning given to each of the terms in different countries, the American College of Emergency Physicians defines the term emergency medical condition as *"Any condition perceived by the prudent layperson or someone on his or her behalf, as requiring immediate medical or surgical evaluation and treatment."*[26]Likewise, in the relevant literature emergency medical condition is defined as a medical condition that manifests acute symptoms of sufficient severity, which in the absence of immediate medical treatment would reasonably be expected to cause serious jeopardy to the patient´s health, bodily functions, and/or life.[27] This includes results such as serious dysfunction of any bodily organ or part.[28] Similarly, it can be observed that this same formula is employed in the laws of many countries.. For instance, the US law on emergency medical condition, EMTALA defines emergency medical condition as follows;[29]

> *"(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:*
>
> *1. Serious jeopardy to patient health, including a pregnant woman or fetus.*
>
> *2. Serious impairment to bodily functions.*
>
> *3. Serious dysfunction of any bodily organ or part.*
>
> *(b) With respect to a pregnant woman:*
>
> *1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;*
>
> *2. That a transfer may pose a threat to the health and safety of the patient or fetus; or*
>
> *3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes."*

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[26] *Emergency Medicine: Introduction, < http://quizlet.com/12725854/emergency-medicine-introduction-flash-cards/>* visited on 24 February 2014. This definition gives the judgment of the situation whether it is an emergency condition or not to the victim, or person on the side of the victim. It did not also restrict the service to the pre-hospital medical service.

[27] James M. Brown (2011), Essentials of Emergency Medicine (2nd. Ed, Jones & Bartlett Learning
Canada) Richard V. Aghababian ed.), Regulatory Issues, 1029.

[28] *Ibid.*

[29] *See,* U.S. Code, Title 42, Chapter 7, Subchapter XVIII, Part E, §1395dd.

In addition to this, the Indian Law Commission adopted the verbatim copy of latter definition in giving meaning to the term emergency medical condition.[30]Similarly, in Ethiopia a person under emergency medical condition is defined as a patient who seeks medical attention at a health care facility for immediate treatment in order to preserve life or address a serious medical state that would affect the long time health condition of the patient.[31]

Furthermore, emergency medical treatment is defined as a medical treatment given for a patient under emergency medical condition with a view to stabilize him/her. It refers to "a [ ] service dedicated to providing out of hospitals acute medical care and/or transport to definitive care to patients with illness and injuries which the patient or the medical practitioner, believes constitutes a medical emergency".[32] In this respect, if such treatment is not given for the patient, s/he would reasonably suffer from weakened bodily functions, serious and lasting damage to his/her body or any of his/her organs, or at times die.[33]In

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[30] *See* Law Commission of India, *supra* note 19. The position taken by the Indian Law commission after a detailed research on several countries experiences a person is said to be in an emergency condition where;

> *"an individual's medical condition manifest acute symptoms of sufficient severity (including severe pain) where the absence of emergency medical treatment could reasonably be expected to result in:*
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> *(i) death of the person,*
> *(ii) serious jeopardy in the health of the person (or in the case of a pregnant woman, in her health and the health of the unborn child), or*
> *(iii) serious impairment of bodily functions,*
> *(iv) serious dysfunction of any bodily organ or part"*

[31] Ministry of Health, National Admission and Discharge Protocols for Ethiopian Hospitals (2012), p. 11. (hereinafter the Admission and Discharge Protocol for Ethiopian Hospitals)

[32] Canadian Emergency Medical Services Lead the Way!, <http://www.theogm.com/2012/08/10/canadian-emergencymedical-services-lead-the-way/> visited on 5 January 2013.

[33]Emergency Medical Conditions, <https://www.medicalschemes.com/medical_schemes_pmb/emergency_medical_conditions.htm>, last visited on 12th June 2015. In the European Union, emergency medical treatment is considered as part of emergency medical services that entitle a person under emergency medical condition the right to get appropriate medical screening, in-patient and outpatient treatment that targets stabilization, and transfer. In this respect, in Union emergency medical services system refers a broad and integrated health care system model which is a sub-set of the Emergency Heath System, and includes screening, stabilization, reporting an emergency, administrative and institutional oversees over emergency medical providers, resource allocation and facilitation. Emergency Health Services System on the other hand encompasses a broader domain that includes the consequences of management of disasters, war, civil unrest,

relation to this, it seems that the purpose of the right is to ensure that medical treatment be given to the patient/victim immediately, and that the treatment is not frustrated through bureaucratic requirements or other formalities.[34]

In conclusion, depending on the latter premises one can easily conclude that, first, all emergency perils are not emergency medical conditions. Second, it is only those emergency perils with severe magnitude that entitle a patient to an emergency medical treatment; and the scope of the latter may differ from country to country. However, on the general formula, there seems to be an agreement in all countries as to what constitutes an emergency medical condition and treatment.

2.2 The Concept of Emergency Medical Condition and Treatment under Ethiopian Laws

i. *The Concept of Emergency medical Condition and Treatment under Food, Medicine and Health Care Administration and Control Proclamation*

In Ethiopia, the issue of emergency medical condition and treatment is addressed in the Food, Medicine and Health Care Administration Proclamation,[35]and the Regulation[36] that followed it. According to the Proclamation, any health professional is obliged to give emergency medical treatment within the scope of his/her professional practice.[37] In association with this, the Regulation defines emergency medical treatment as a medical treatment provided in health institutions by a health professional to a patient suffering from a disease or injury that could result in imminent and life

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terrorism, epidemics. World Health Organization (2008), Emergency Medical Services System in the European Union: Report of an Assessment Project coordinated by World Health Organization, pp. 17 and 50.

[34] *Soobramoney* v. *Minster of Health*, *supra* note 17, § 20.

[35] Food, Medicine and Health Care Administration and Control Proclamation No. 661/2009, Federal Negarit Gazeta 16th Year No. 9 ADDIS ABABA 13th January, 2009 (hereinafter Food, Medicine and Health Care Administration and Control Proclamation).

[36] Food, Medicine and Health Care Administration and Control Council of Ministers Regulation No. 299/2013, Federal Negarit Gazeta 20th Year No. 11 ADDIS ABABA 24th January, 2014 (hereinafter Food, Medicine and Health Care Administration and Control Regulation).

[37] Food, Medicine and Health Care Administration and Control Proclamation, Article 38(1).

threatening or permanent health problem. This indicates that the obligation requires medical institutions to stabilize a patient under emergency medical condition.[38] Moreover, the Regulation requires a medical practitioner to transfer /immediately refer/ a patient under emergency medical condition to the appropriate medical institution that has the capacity to treat the patient in case stabilization is not possible given the health institution's standard and resources.[39]In this regard, such transfer is required to go through the referral system[40] which is a system regulated through a guideline issued by the Ministry of Health.[41]

On the other hand, though the Proclamation provides an obligation to give emergency medical treatment, it does not expressly require the treatment to be given freely. However, though this is not the case the purpose of the provision is to require medical institutions to give free emergency medical treatment.[42]In other words, the emergency medical treatment required in the Proclamation and its subsequent regulation is the right to get free emergency medical treatment. Moreover, if one looks at the Addis Ababa City Administration Health Service Provision and Health Institutions Control Directive, it is noticeable that all medical institutions found in the City are required to give emergency medical treatment without pay.[43]This is a reflection of the spirit of the Proclamations that emergency medical treatment should be given without pay.

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[38] Food, Medicine and Health Care Administration and Control Regulation, Article 2(39).

[39] Food, Medicine and Health Care Administration and Control Proclamation, Articles 38 (1) & (2); *see* also, Food, Medicine and Health Care Administration and Control Regulation, Articles 53 and 54.

[40] Food, Medicine and Health Care Administration and Control Proclamation, Article 38 (2); Food, Medicine and Health Care Administration and Control Regulation, Article 54.

[41] FDRE Ministry of Health Guideline for Implementation of a Patient Referral System (May 2010). (hereinafter the Referral Guideline)

[42] Interview with Mr. Getnet Desta, Legal Officer at the Ministry of Health 22nd June 2015.

[43] Addis Ababa City Administration Provision of Health Service, Health Institutions Administration and Guidance Directive No. 26/2009, (hereinafter Addis Ababa City Provision of Health Service and Health Institutions Administration Directive)Article 11(e). Note that, the author sees only Addis Ababa Administration's Directive. In this regard, it is also expected from regional governments to come up with such stipulation, in case they have no.

ii. Emergency Medical Condition and Treatment under the Social Health Insurance Proclamation

The issue of emergency medical treatment is has recently been addressed in the social health insurance scheme.[44] One of the entitlements given for a beneficiary of the Social Health Insurance Scheme is the right to get outpatient health care service from health facilities that concluded a contract with the Ethiopian Health Insurance Agency to give a health service package for the beneficiaries of social health insurance.[45] In this regard, emergency medical treatment is part of outpatient care service under the Social Health Insurance Proclamation. Therefore, the scheme recognizes emergency medical treatment for the beneficiaries of the latter. Moreover, Article 5(1) of the regulation stresses that a beneficiary of the Insurance scheme shall follow a referral system except for *emergency cases.*[46]This provision also indicates that emergency medical treatment is recognized under the Social Health Insurance Scheme.

However, it is important to note that, the Scheme does not benefit all citizens. It is only citizens specified under Articles 5 and 7 of the Proclamation that are beneficiaries of the scheme.

iii. Emergency Medical Condition and Treatment under Motor Vehicle Insurance against Third Party Risks Proclamation

Proclamation No. 559/2008[47] and the newly enacted Vehicle Insurance Against Third Party Risks Proclamation No. 799/2013 that replaced the former came up with a new approach towards emergency medical condition and treatment. The former Proclamation for the first time, in Ethiopian history, provides an express stipulation that requires medical institutions and their personnel to

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[44] In fact, under the Social Health Insurance Proclamation there is no provision that expressly state emergency medical treatment is part of the social health insurance scheme the recognition of outpatient care and a cross reference to Article 5 of the Social Health Insurance Scheme Regulation is indicative as to the incorporation of emergency medical treatment in the scheme.

[45] Social Health Insurance Scheme Regulation, Article 3(1)(a).

[46] The Amharic version states, <<ከድንገተኛ ሕክምና አርዳታ በስተቀር>>

[47] Vehicle Insurance Against Third Party Risk Proclamation No. 559/2008, Federal Negarit Gazeta 14thYear No 7 Addis Ababa 9th January 2008.

extend free medical service for all victims of motor vehicle accidents.[48]The latter also incorporated the same with a view of facilitating emergency medical treatment for victims of motor vehicle accident.[49]

Article 27(1) of the Vehicle Insurance Against Third Party Risks Proclamation entitles any person that sustains injury from motor vehicle accident to an emergency medical treatment to a maximum of Birr 2,000 (104.53 USD).[50] In doing so, the provision entitles the right to everyone,[51] including the perpetrator of the accident. Even though perpetrator causes the accident deliberately s/he fully benefits from this scheme.[52]This is because Article 27 does not make any other qualification than being a victim. The law indiscriminately treats victims of accident irrespective of one's contribution for the occurrence of the accident. This, on the other hand, indicates that the law wants the perpetrator to be rescued for s/he could face the consequences of his/her wrong.[53] However, the Proclamation does not define the term emergency medical condition. Nevertheless, among others, relying on reference to the meaning given to the term emergency medical treatment[54] and the spirit of the provision one can infer the meaning emergency medical condition within this proclamation.

Initially, it is important to note that Article 27(1) of the Proclamation gives the right to emergency medical treatment for victims of accident. Accordingly, when it says a person is entitled to medical treatment it refers only to an *emergency medical treatment*. The law does not entitle a right to get other

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[48] Vehicle Insurance Against Third Party Risk Proclamation, Article 27.
[49] Vehicle Insurance Against Third Party Risk Proclamation, Preamble para. 2.
[50] The calculation is made based on the exchange rate on January 30, 2014 in the Commercial Bank of Ethiopia S.C, i.e., 1USD= 19.1315 ETB. *See* Commercial Bank of Ethiopia, <http://www.combanketh.et/More/CurrencyRate.aspx>, visited on 30 January 2014.
[51] The provision stipulates that any person that sustained injury due to vehicle accident is entitled to treatment irrespective of whether s/he is defined under the Proclamation or not as a beneficiary of compensation.
[52] Vehicle Insurance Against Third Party Risks Proclamation, Article 27. Even though the perpetrator was in a suicide mission, the medical institution shall treat him/her so that h/se can be brought to justice. Moreover, the presumption of innocence compels one to do the same.
[53] Law Commission of India, *supra* note 19.
[54] The incorporation of a meaning for the term "emergency medical treatment" is one of the new developments under the Proclamation. In the repealed Proclamation, the term was not defined. Rather, it was the Directive on Emergency Medical Treatment issued in accordance with it that used to provide a same verbatim meaning to the term under its Article 3(7).

treatments. Therefore, this implies the importance of identifying the presence of emergency medical condition. In relation to this, in order to get the specific meaning of the terms emergency medical condition and treatment it is necessary to resort to the relevant literature.

In this respect, as it is discussed in the previous section, emergency medical condition refers to a situation where the victim manifests a serious medical state to his/her life and/or health.[55] It refers to a health condition that requires immediate medical treatment and/or operation in which unless treatment is made available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death to the victim.[56] In such a way, one can definitely identify victims eligible for treatment. However, in doing so it is important to follow a liberal construction. Accordingly, every victim of motor vehicle accident should be deemed to have a *prima facie* emergency medical condition.[57] This is important to avoid bitter consequences that may follow the contrary presumption. If one presumes the existence of an emergency medical condition in relation to all victims of motor vehicle accidents, the victims will at least get first aid and will be screened all the time. Therefore, all victims of motor vehicle accident should be diagnosed and screened to determine the presence of an emergency medical condition. Following the screening, if the victim is diagnosed to as having an emergency medical condition, efforts to stabilize his condition will continue. However, if the victim does not have a critical medical condition s/he will be given first aid services for minor injuries and scratches, and get discharged.

3. Procedures Medical Institutions and their Employees should follow at times of Emergency Medical Treatment

There are procedures that should be followed by emergency medical treatment providers: medical institutions and their practitioners. Moreover, there is a standard of care expected from the latter in order to provide an effective medical treatment for a victim. Therefore, this Section is devoted to explaining

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[55] Admission and Discharge Protocol for Ethiopian Hospitals, p. 11

[56] *Ibid.*

[57] Emergency Medical Conditions, *supra* note 33.This is because it is not always possible to diagnose the presence of emergency medical condition on the patient before admitting hi/her for treatment.

and examining the procedure that should be followed in offering emergency medical treatment. Throughout the discussion the practical reality in Ethiopia is also examined. Such examination is necessary in order to identify any discrepancies that might exist between the standard procedure laid out in regulatory emergency schemes and the actual practice on the ground.

In general, the proven proper procedures that should be followed by medical institutions and their personnel during emergency medical treatment can be categorized into two or three. In the strictest sense, the obligations of hospitals and medical institutions can be classified into two: obligation to screen and obligation to stabilize a patient before transfer or discharge.[58]On the other hand, in the broadest sense, the obligation incorporates an obligation to screen, stabilize and transfer a patient.[59]

3.1 Obligation to undertake Medical Screening

Medical screening is a diagnosis undertaken by a medical practitioner to identify the presence, magnitude and type of medical complications.[60] It refers to an inevitable procedure in any medical treatment that allows a practitioner to extend the appropriate treatment.[61]In general terms, medical screening is all about information gathering. It is a means through which the medical practitioner knows the medical state of an individual.[62] Then the information

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[58] E. C. Liu (2010), EMTALA: Access to Emergency Medical Care (Congressional Research Service) p. 11.

[59] R. A. Bitterman, 'Transferring and Accepting Patients under EMTALA', *Providing Emergency Care under Federal Law: EMTALA* (Chapter 7) p. 103.

[60] Medical Screening and Surveillance, <https://www.osha.gov/SLTC/medicalsurveillance/> , visited on 23 August 2013; *See also,* J. Zibulewsky (2001), 'The Emergency Medical Treatment and Active Labor Act (EMTALA): what it is and what it means for physicians', *Baylor University Medical Center Proceedings* (Volume 14, Number 4) p. 340. EMTALA states that, "In the case of a hospital that has a hospital emergency department, if any individual [ ] comes to the emergency department and a request is made []. for examination or treatment for a medical condition, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department to determine if an emergency medical condition exists."

[61] R. S. Ledley and L. B. Lusted (Jul. 3, 1959), 'Reasoning Foundations of Medical Diagnosis', *American Association for the Advancement of Science* (Science New Series, Vol. 130, No. 3366) p. 9, <http://www.jstor.org/stable/1758070>, visited on 2 January 2014.

[62] Definition of Emergency Medicine, <http://www.emergencymedicine.in/EMFAQ/EMdefinition.htm.>, visited on 4 January 2014.

gathered through screening will be used to undertake the proper action to heal the patient.[63] Therefore, in order to get the most reliable information the medical practitioner may investigate both the present medical state of the patient and his/her medical history.[64]In fact, the present state of the victim can be examined through physical and laboratory examinations undertaken in the medical institution after the victim has sustained the injury.[65] On the other hand, the medical history of the victim is gathered from hospital records and medical personnel that treated the victim in earlier times, including, the patient's personal physician.[66] Therefore, for any medical condition necessitating treatment medical screening is necessary to detect the presence of an emergency medical condition, and identify its medical complications and magnitude. This is because appropriate medical screening is indispensable for appropriate treatment.[67]Accordingly, a person under an emergency medical condition should be diagnosed before treatment.[68]

In this regard, the medical institution where the victim is found should appoint qualified personnel that could diagnose the victim.[69] The medical personnel can either be a physician or non-physician.[70] However, s/he must be qualified to diagnose the victims' medical condition.[71]Such diagnosis includes checking

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In fact, primarily when the patient is brought to a medical institution emergency is defined by the perception of the patient or the attainders that bring the patient to the emergency department. What the emergency physician perceives may not be the same.

[63] Ledley and Lusted, *supra* note 61.

[64] *Ibid.*

[65] *Ibid.*

[66] "Screening exam should include appropriate medical history, physical examination, and diagnostic testing; consulting with pertinent on-call physicians or other health care providers; and reassessing the patient prior to discharge/transfer." *See* www.ena.org/government/emtala/article2asp; *See also,* Trauma Assessment, <http://www.patient.co.uk/pdf/217.pdf>, p. 4, visited on 15 November 2013.

[67] United States General Accounting Office, (2001), EMERGENCY CARE EMTALA: Implementation and Enforcement Issues, p. 16, <https://www.google.com.et/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&ved=0CCUQFjAA&url=http%3A%2F%2Fwww.gao.gov%2Fnew.items%2Fd01747.pdf&ei=fK0MU66KMYKKyAPw1YDQBg&usg=AFQjCNFem0vkhMU8rjzvJZyt1h4l-B1UpA&bvm=bv.61725948,d.bGQ,> visited on 15 January 2013.

[68] Liu, *supra* note 58, p. 3.

[69] Certification and Compliance for the Emergency Medical Treatment and Labor Act (EMTALA), p. 3, <https://www.cms.gov/Medicare/Provider-Enrollment-and Certification/CertificationandComplianc/downloads/EMTALA.pdf> , visited on 12 June 2013.

[70] *Ibid.*

[71] *Ibid.*

for vital signs, [72]medical history of the victim,[73] physical examination[74] and laboratory tests.

Moreover, in order to determine whether legally stipulated standards necessary to say that a person is under emergency, it is necessary to diagnose him/her in advance. Even though a person came with a *prima facie* emergency medical condition, it is after medical screening that the practitioner will determine whether the patient is under emergency medical condition. This shows, medical screening serves two purposes: to determine both eligibility to emergency medical treatment and give the appropriate treatment necessary to stabilize the victim.

Under the Ethiopian legal system, neither the Motor Vehicle Insurance Against Third Party Proclamation, nor other laws, and subsequent directives that followed it have clearly made medical screening mandatory. However, this does not mean that medical screening is not necessary. Since medical screening is inherently necessary to administer appropriate medical treatment it should always be administered. The medical practice requires this. Therefore, medical

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[72] G. M. Garmel, 'Approach to Emergency Patient', in S. V. Mahadeevan and G. M. Garmel (eds., 2005), *An Introduction to Clinical Emergency Medicaine*(Cambridge University Press, New York) p. 9. Checking on vital signs include checking the heart rate of the patient, respiratory system lines and the temperature of the victim as the case may be. Vital signs are promptly checked because they are scientifically proved important to identify complications in all emergency patients.

[73] Department of Health and Human Services, Center for medicine and medical services, *Medical Program; Clarifying Policies Related to the Reasonableness of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions* (Vol. 68, No. 174) (Federal Register, 42 CFR parts 413, 482 and 489)Final Rule , p. 53225. Nonetheless, it is important to recall the fact that consulting the medical history of the victim shall not jeopardize the interest of the victim. If such consultation would delay or affect the immediate treatment of the victim then it shall not be effected. Rather, in such circumstances the medical personnel shall turn its face to stabilizing the medical condition of the victim. Normally, at some points differentiating medical screening and stabilization may become difficult. Even more, sometimes they may come concurrently. Legislatures and medical practitioners also believed this. It may be hard to determine at what specific point stabilization begin, of screening ends. However it is important to note that the existence of screening and stabilization can be determined y medical practitioners in accordance with the practice in the profession and logic

[74] Garmel, *supra* note 72, p. 8. Physical examination concentrates on the general appearance of the patient and checkups made on focus areas of the human body. This includes examining areas of the body that may contribute to the condition may allow emergency personnel to prioritize the likelihood of other diagnoses causing the symptoms.

screening is always mandatory. In this regard, it is important to note that medical screening shall be interpreted broadly. At times, the emergency condition is unconcealed, one can identify the medical condition through customary examination, this includes on sight medical examinations through perceptions via sense organs (e.g., by looking the reaction of the patient). On the other hand, the medical screening may become tough and technical, in a way that the medical personnel should even use laboratory tests in order to identify whether there exists an emergency medical treatment. Related to this, identifying whether the patient's medical condition is the direct or indirect consequences of motor vehicle accident itself requires an appropriate medical screening. The medical screening can also be undertaken either by physicians or formally appointed non-physician practitioner capable to undertake the same.[75]This is justified through the usage in the medical industry[76] and the very low physician/patient ratio in Ethiopia.[77]Nevertheless, in Ethiopia, during medical screening the practice of resorting to the medical history of the victim is very poor. Moreover, medical institutions and their personnel, especially in private medical institutions claim that the victim should in advance cover the cost for medical screening.[78]

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[75] Todd B. Taylor (2011), Emergency Medical Treatment & Labor Act (EMTALA), (American College of Emergency Physicians), p. 17, <http://www.google.com.et/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0CCIQFjABahUKEwjw57mNjMnHAhUJPxQKHebDAsQ&url=http%3A%2F%2Fwww.acep.org%2FuploadedFiles%2FACEP%2FMeetings_and_Events%2FEducational_Meetings%2FEDDA%2FPhase_II%2F26%2520Taylor%2520-%2520EMTALA.pdf&ei=z-veVbDEHIn-UOaHi6AM&usg=AFQjCNFK6Jf3-2wDaGdhs7gL4kA387eZIw>, visited on 27th August 2015. A non-physician practitioner may include interns and public health professionals.

[76] Ledley and Lusted, *supra* note 61.

[77] World Health Organization Global Health Workforce Alliance, Country Case Study: Ethiopia's Human Resources for Health Programme, p. 3, <https://www.google.com.et/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&ved=0CCIQFjAA&url=http%3A%2F%2Fwww.who.int%2Fworkforcealliance%2Fknowledge%2Fcase_studies%2FEthiopia.pdf&ei=pbUMU-z5F6m57AaKpYGoAw&usg=AFQjCNGX2cG323hIu-1CwyPoAmgcOGH-Qg&bvm=bv.61725948,d.Yms>, visited on 12 August 2013. Sticking to physician practitioners would not be possible due to lack of number of physicians in Ethiopia. In a country where the physician patient ration is 1:29,777 allowing only physicians to undertake medical screening is not realistic.

[78]According to a pilot survey made by the author in medical institutions located in Addis Ababa, Bishoftu, Adama and Jimma, 76.68% of respondents working in medical institutions

Lastly, the obligation of the institution to screen the patient is limited by the equipment, facilities, and expertise the medical institution has.[79] If the medical institution has no competence to identify the threatening medical condition of the patient, it should screen and attempt to stabilize the patient to the extent possible in its competence. Afterwards, the medical institution may transfer the victim to a better medical facility.[80]

3.2 Obligation to Stabilize

In ordinary parlance, stabilization refers to a firm and dependable state free from fluctuations.[81] Similarly, in medical law stabilization refers to providing treatment for a patient under emergency medical condition with a view to stabilize his/her medical condition.[82] Instantly, a stable medical condition refers to a medical condition in which there is a reasonable medical certainty that material deterioration of the patient's medical state would not occur at during transfer or discharge.[83]This stability could be stability of physical or psychological health.[84] Hence, from the above stipulation one can infer two things: *stability for transfer* and *stability for discharge*. The medical condition of a patient is said to be ***stable to transfer*** when it is reasonably certain that his/her medical condition would not materially worsen during transfer.[85] On the other hand, the medical condition of the patient is considered ***stable for discharge*** when his/her medical condition reasonably let a prudent medical

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claim that emergency medical treatment is given to a victim of motor vehicle accident only if s/he covers the cost of medical screening and stabilization in advance. In addition to this, 18% of the respondents stress that the victim shall cover the cost for card and other medical accessories, such as glove, syringe and glucose. Moreover, 4.58% of the respondents believe the victim should cover the cost of every emergency medical procedure except professional assistance. It is only 0.75% of the respondents that believe the victim shall not be obliged to cover the cost of treatment before 48 hours.

[79] Enhancing Public Health Delivery System in India, p. 29, <http://saneinetwork.net/Files/10_05___M_P_Ram_Mohan.pdf>, visited on 13 August 2013.

[80] Note that the issue of transfer is dealt in subsequent heading. However, readers should note that the medical institution is out rightly obliged to transfer the victim to a better facility. Rather, this matter is not clearly regulated under the Ethiopian legal system.

[81] *Merriam Webster's Dictionary*, *supra* note 11.

[82] Taylor, *supra* note 75 p. 13.

[83] Liu, *supra* note 58, p. 4.

[84] Managing Emergencies and Traumatic Incidents, p. 10, <www.minedu.govt.nz/~/.../**Emergency**Management/TheGuideS m.pdf> *visited on 15 August 2013.*

[85] United States General Accounting Office, *supra* note 66.

practitioner conclude that s/he can be treated as an outpatient or hospitalization can be deferred.[86]

Therefore, the obligation to give emergency medical treatment extends until the individual under emergency medical condition is discharged, hospitalized or transferred to another medical institution before hospitalization.[87]In association with this, in the latter regime if an individual's medical condition is not convenient to transport him/her to another medical institution, or if an intense bleeding is not stopped one cannot say that a patient's medical condition is stabilized.[88] Consequently, among other procedures, stabilization involves extending first aid to a victim under emergency medical condition. Hence, stabilization may be either simultaneous with medical screening or it may come after medical screening.

Once the presence of emergency medical condition is ascertained stabilization is compulsory.[89]If it is proved that there exists an emergency medical condition, medical institutions and their personnel are obliged to offer the necessary treatment based on the institutions capability and capacity for the victim with a view to stabilize him/her.[90]In fact, the instance where a patient's health is said to be stable is open for argument. A medical state one practitioner believes is to be stable might not be the same for another practitioner. For this reason, it is important to provide a proper standard to determine when one shall

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[86] *Ibid.*

[87] Liu, *supra* note 58, pp.5-6. World Health Organization, *supra* note 33, p. 50. In countries like USA and member states of the European Union,

[88] Bitterman, *supra* note 59.

[89] Liu , *supra* note 58, p.6.

[90] Certification and Compliance for the Emergency Medical Treatment and Labor Act, *supra* note 68, p.2. In addition to this, the experience of other jurisdictions prove that a medical institution may transfer a patient under emergency medical condition if it does not have the necessary capability and capacity to stabilize the patient, or if waiting stabilization in that medical facility would take time and is of high risk to the patient. In such cases, the transfer is made before the patient is fully stabilized.[90] Nevertheless, in these jurisdictions medical institutions and their personnel can order transfer after ascertaining the existence of the above two exceptional conditions, and up on the fulfillment of conditions necessary to order transfer. These rigorous provisions that regulate transfer are also known as *patient anti-dumping provisions.* Moreover, if a medical institutions and its practitioners transfer a patient violating these conditions they will be held liable. Due to this, medical practitioners did not obstruct them mostly. The requirements for transfer are dealt in the next sub-heading. *See,* Zibulewsky *supra* note 60, p. 344.

say the medical condition of a patient is stable. In making such a determination, the researcher believes that it is important to take a prudent medical practitioner as a threshold. In other words, one should make the same determination that an objective and reasonable medical practitioner in a similar circumstances would make regarding whether a patient is stabilized.[91] Other than this, the expertise of the practitioner, his/her age, experience and so on shall not be taken in to consideration. The practitioner should be judged by the standard of his/her peers.[92] This is because, if one is highly inclined to the subjective standard, it would give a wide leeway for the violation of the obligation.

In Ethiopia, medical institutions and their employees have an obligation to stabilize victims of motor vehicle accident under emergency medical condition. According to article 27(1) of Motor Vehicle Insurance Against Third Party Risk Proclamation, any victim of a motor vehicle accident is entitled to medical treatment, in any medical institution, to a maximum of ETB 2,000. This means, once it is identified that a victim of a motor vehicle accident is under emergency medical condition, the medical institution and its personnel are obliged to provide medical treatment to the victim.[93] Consequently, the obligation of medical institutions and their personnel is not curing the patient; it is rather stabilizing him/her.[94]In this regard, the National Admission and Discharge Protocol defines clinical stability as a condition, where, the patient's vital signs are found to be within an acceptable/normal range after blood tests and further investigations.[95] Accordingly, the type of treatment that should be offered to the victim should be a treatment that would bring a reasonable medical certainty to his/her medical state.[96] By doing so, if the patient's medical condition is stabilized before the institution spends the maximum legal amount specified above it will not be obliged to extend further treatment to the victim without advance payment. However, a problem arises in the Ethiopian

[91] A. Grubb (ed.) (2004, 2nd edn.), *Principles of Medical Law* (Oxford University Press, USA) p. 371.
[92] *Ibid,* p. 370.
[93] Vehicle Insurance Against Third Party Risk Proclamation, Article 27(1).
[94] Under Emergency medical treatment laws, the primary obligation of hospitals is to stabilize the patient. When they act they should act with a view of stabilizing the patient, and not with a view of curing. *See* Zibulewsky, *supra* note 60, pp. 342-543.
[95] Admission and Discharge Protocol for Ethiopian Hospitals, p. 11.
[96] Liu, *supra* note 58, p. 4.

legal system when one raises questions such as, "Is the legally stipulated amount sufficient to cover the cost of stabilization?", "What would be the fate of a victim if s/he is not stabilized after getting treatment to the maximum legal amount?", "Wouldn't the difference in amount charged in privately owned medical institutions for diagnosis and treatment affect the emergency scheme?",[97]and, "To what extent does the obligation to give emergency medical treatment extend to medical practitioners working in private wing's in government hospitals?" Such questions are ongoing concerns that do not seem to have answers within the existing relevant laws.

As it is stressed in the previous paragraph, the first concern that requires a solution relates to the adequacy of the legally stipulated maximum amount for treatment. In relation to this, primarily a problem arises due to the position taken by the lawmaker. The lawmaker has limited the scope of medical institutions obligation through monetary terms rather than providing a general formula for stabilization. In other words, had the lawmaker determined the scope of treatment using terms such as, '... *medical institutions are obliged to stabilize the victim*" than determining the obligation of medical institutions through reference to a specific amount of money, this problem could have been avoided. [98] Consequently, it is recommended if the lawmaker replaces the present stipulation with a general standard dictating stabilization. Nevertheless, if the legislature does not accept the latter recommendation and sticks to limiting the amount to be paid for emergency medical treatment in monetary terms, it is would have been better to delegate the authority to determine the

[97] This is because the amount medical institutions charge for their service will affect the scope of treatment the person under emergency medical care would get. Exorbitant fees charged for treatment in some privately owned medical institutions is also threatening the emergency medical treatment scheme, An interview with Mr. Tilahun Melaku, an official in FDRE Ministry of Health,

[98] The writer argues that such formulation is supported by other rationales. First, the rationale behind the incorporation of an obligation to give emergency medical treatment is to reduce trauma. The primary aim of the Proclamation is establish a system that facilitates the provision of emergency medical treatment for victims of vehicle accident. Therefore, this being the primary aim of the lawmaker, *i.e.,* reducing trauma, it was better if it simply stressed that medical institutions are obliged to give primary health care services and stabilize the patient. Conversely, the present stipulation in the law chiefly risks the interest of individuals with serious bodily injury. Second, the lawmaker oversees matters associated with inflation in fixing the legal maximum. Due to this, in order to fight the problem that may arise due to inflation it would have been better if the lawmaker opted for a different stipulation. *See,* Vehicle Insurance Against Third Party Risk Proclamation, preamble para. 3.

legal maximum amount to another organ, particularly to the Council of Ministers. This could be a better solution to accommodate economic changes easily.[99]Such an arrangement will make the stipulation of the maximum amount flexible for change.

Nonetheless, even in the presence of such stipulation that limits treatment to a maximum of ETB 2,000, the author argues that, medical institutions and their personnel cannot abandon treating a victim of motor vehicle accident for simple reason that the cost of treatment has reached ETB 2,000. A closer look at the Food, Medicine and Health Administration and Control Proclamation, and the Addis Ababa City Administration Provision of Health Service and Health Institutions Administration Directive gives an indication as to this possibility of extended emergency medical treatment. The Food, Medicine and Health Care Administration and Control Proclamation impose an obligation to provide an ongoing emergency medical treatment for patients under emergency medical condition.[100] Following this, Addis Ababa City Administration Provision of Health Service and Health Institutions Administration Directive provides that all health institutions found in Addis Ababa are required to give a 24-hour free emergency medical treatment for any individual under emergency medical condition.[101] Accordingly, the author is of the opinion that an obligation to give emergency medical treatment should extend for victims of motor vehicle accident even beyond the legal maximum ETB 2,000 in case the victim of motor vehicle accident is not stabilized. This is because, Motor Vehicle Against Third Party risk Proclamation is not issued in order to narrow the right of a victim that she or he is entitled in other legislations. On the other hand, though the Food, Medicine and Health Administration and Control Proclamation establishes a right to emergency medical treatment, it does not expressly require the treatment to be given freely. However, the understanding is that medical institutions are obliged to give emergency medical treatment freely.[102]As a result, in order to make the extent of the obligation clear and

[99] Inflation is substantially changing the economic reality in Ethiopia. For this reason, if the provision is kept like this we would witness what a change of circumstances did cause to the maximum amount to be paid for moral damage in Article 2116(3) of the Ethiopian Civil Code.
[100] Food, Medicine and Health Care Administration and Control Proclamation, Article 38.
[101] Addis Ababa City Administration Provision of Health Service and Health Institutions Administration Directive, Article 18(1).
[102] Interview with Mr. Getnet Desta, *supra* note 42.

avoid ambiguity, the Ministry of Health should come up with a directive that stipulates the same.

3.3 Obligation to Transfer

Transfer is a broad concept inherent in emergency medical treatment schemes.[103] In a broader sense, it refers to moving a thing/individual from place to place.[104]However, in emergency medical treatment laws the meaning of transfer is limited. Transfer does not include every movement of a patient within the premises of the medical institution.[105] Moreover, neither discharge of dead body of a victim, nor departure of a victim of motor vehicle accident without the permission of the medical institutions personnel is regarded as transfer.[106] Narrowly constructed, in emergency medical treatment laws, transfer refers to one of the following three: moving a patient under emergency medical condition from the site of accident to a hospital, transferring a patient from one medical institution to another, and discharging a patient under emergency medical condition from a medical institution after stabilization.[107] The former type of transfer is called primary transfer; whereas, the latter two are called secondary transfer.[108]

Primary transfer is effected when stabilizing the patient at the site of accident is not possible. Secondary transfer can be of two types. The first type of secondary transfer is discharge. As the nomenclature dictates, discharge refers to either releasing the patient after appropriate stabilization, or else admitting a patient as an inpatient in the medical institution for further treatment. On the other hand, the other type of secondary transfer is transferring a patient from one medical institution to another. This type of transfer could either be referral, or transfer administered through the victims informed request.[109] Referral is

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[103]M. J. G. Dunn *et al* (2006), Critical care in the emergency department: patient transfer, *An Occasional Series on Critical Care*, p. 40, <www.ncbi.nlm.nih.gov?pmc?articles/PMC2658153/pdf/40.pdf>, visited on 26 February 2014.
[104] *Merriam Webster's Dictionary*, *supra* note 11.
[105] Bitterman, *supra* note 59.
[106] *Ibid.*
[107]*Ibid.*
[108] Dunn *et al*, *supra* note 103.
[109] Note that the term "through the victims informed request", include a transfer administered through the informed request of the victim or his/her representative.

principally administered when stabilizing the victim is beyond the capacity of a medical institution.[110] During such times, the referring medical institutions medical personnel should do their best to examine the medical conditions of the victim, provide him/her all possible stabilizing treatments up to the institutions competence,[111]undertake appropriate assessment concerning the potential risks and benefits of the transfer, and order the transfer if the benefits of the transfer overweight the risk.[112]During such times, if the law allows free emergency medical treatment the referring medical institution should transfer the victim irrespective of his ability to pay, or insurance coverage limit.[113] Note that such medically indicated transfer is administered after the authorized medical personnel in the medical institution authorizes the transfer.[114]

Alternatively, as it has been indicated above secondary transfer can be effected through the victims informed request.[115]During such times, the premise is that there exists no medically indicated transfer. Or it might be the case that the victim can get an equal or better treatment from the medical institution to which she or he is being transferred to. It is also possible that, s/he requires the transfer for other reason that s/he or his/her representatives have in mind. During such times, the victim should cover the cost of transfer. Moreover, the right to free medical treatment does not persist at the receiving institution.

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[110] World Health Organization, *supra* note 33, p.44.

[111] Certification and Compliance for the Emergency Medical Treatment and Labor Act, *supra* note 68, p. 2. Such medically indicated transfer is administered either due to lack of qualified personnel and/or equipment in the medical institution. *See* Bitterman, *supra* note 59, p. 104.

[112] Taylor, *supra* note 75, p. 4. The transfer of unstable patient should be made through qualified personnel and appropriate equipment. Such shall include the provision of appropriate equipments to sustain the life of the victim at the cost of the medical institution. In other words, the ambulance/cab used to transfer a patient must be adequately equipped through both, equipments and personnel. *See* Certification and Compliance For The Emergency Medical Treatment and Labor Act (EMTALA), *supra* note 69, p. 2; South Asia Network of Economic Research Institute (2010), *Enhancing Public Health Delivery System in India: Impact of Judicial Decisions towards Access to Universal Health Care* (New Delhi, The Energy and Resources Institute) (Project Report No. 2008IA05), p. 28.

[113] Zibulewsky, *supra* note 60. In countries that establish government owned primary health care centers like India such primary health care centers should transfer a stabilized patient to government owned medical institutions only where the victim is stabilized. Nevertheless, in other countries there exists no such rule. *See* South Asia Network of Economic Research Institute, *supra* note 112.

[114] Bitterman, *supra* note 59.

[115] *Ibid*, p. 104.

Turning back to medically indicated secondary transfer, the jurisprudence evidences that referring medical institution should meet certain stringent formality requirements before transferring the victim. First, the medical institution should ascertain that the accepting institution has the capacity and expertise to treat the victim's medical condition and secure the consent of the receiving medical institution.[116] In the second place, the medical personnel of the transferring medical institutions should fill a transfer form that evidences transfer is the best option and make the victim sign on it.[117] Nonetheless, if securing the consent of the victim or a person responsible for him/her is not possible the medical institution can transfer the victim without securing his/her consent. This is because emergency medical care schemes always stand for the best interest of the victim. Conversely, if the medical institution claims that the victim refuses the transfer it should prove it using documentary evidences signed by the victim or his/her representative.[118]In the third place, if transfer is effected the transferring institution should send the transfer form and copies of the medical records of the victim together.[119]

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[116] Liu, *supra* note 58, p. 6. The consent of the accepting medical institution is primarily necessitated in order to protect the victim from inconveniences created due to lack of communication among medical institutions. For instance, it is possible to avoid problems that may arise due to denial of admission in the accepting medical institutions for reasons of lack of space in emergency room, and claims of inappropriate transfer. For such reasons countries like USA require the transferring institution to secure the consent of the institution towards whom referral is proposed to be made in advance.

[117] *Ibid*, p. 7. The consent of the victim is necessary because his/her treatment should always be supported by an informed consent. In this regard, the victim's consent for the transfer must be indicated in form prepared by the medical personnel that decides the transfer. This transfer form is a uniform document that primarily summarizes the medical condition of the victim and the reason why transfer is recommended. Note that, the form has a place to record necessary information to identify the patient, the transferring medical institution and the medical personnel that signs the transfer. In other words, the transferring medical institution should provide the reasons for transfer and certify its necessity and let the victim give his/her consent for transfer.

[118]Bitterman, *supra* note 59, p. 107. Refusal must always be proved using the signature of the victim, or his representative on the form prepared for transfer indicating that s/he refuses transfer after s/he is informed the potential risks and benefits of the transfer. Such stringent requirement is imposed on medical institutions in order to protect victims from falsified testimonies of the medical institution's personnel. Instantly, if the patient of his/her legal representative refuses to sign on the document the medical institution should effect the transfer.

[119] Liu, *supra* note 58, p. 6; Bitterman, *supra* note 59, p. 106. Medical records contain relevant details necessary for the proper treatment and management of the patient. Associated with this, a good medical record is a symbol of good practice. Medical personnel are obliged to keep

Accordingly, in countries like the US, unless a medical institution made a transfer fulfilling these conditions one cannot say that the transfer is appropriate one.[120]Such failures would make the institution and the medical practitioner liable.[121]

Under the Ethiopian legal system, an obligation to transfer is clearly stipulated under the Motor Vehicle Risk Against Third Party Proclamation, the Food, Medicine and Health Administration and Control Proclamation, and its subsequent Regulation. Moreover, it is regulated under guidelines issued by the Ministry of Health. In relation to this, the two proclamations indicate the incorporation of both types of transfer i.e. primary and secondary. Primary transfer is incorporated under Article 2(16) of the Motor Vehicle Risk Against Third Party Proclamation. This provision stresses that emergency medical treatment includes medical treatment given to a victim from the site of the accident to an emergency medical ward. Therefore, it indicates that emergency medical condition includes an obligation to transfer a victim under emergency medical condition. Accordingly, primary transfer is explicitly recognized under the Motor Vehicle Risk Against Third Party Proclamation. Nevertheless, this Proclamation does not expressly provide for an obligation to make secondary transfer. However, this does not mean that secondary transfer is not part of the emergency scheme. This is because, one can find secondary transfer inherent in the existing stipulation under the Motor Vehicle Risk Against Third Party Proclamation as well as in in the Food, Medicine and Health Administration and Control Proclamation, the Regulation that followed it, and the mandatory Referral Guideline issued by the Ministry of Health. The latter laws provide for secondary transfer for all persons under emergency medical condition, including victims of motor vehicle accident.[122]

In this regard, the first type of secondary transfer, i.e., discharge, is impliedly recognized under the Motor Vehicle Risk Against Third Party Proclamation. In association with this, this type of transfer stems from the inherent purpose of

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detail, accurate, legible, comprehensive and contemporaneous notes in a medical record for it is necessary to extend appropriate treatment for patients.

[120] Liu, *supra* note 58, p. 7.

[121] *Ibid.*

[122] Food Medicine and Health Care Administration and Control Proclamation, Article, 38(2); Food Medicine and Health Care Administration and Control Regulation, Article 54(2).

emergency medical treatment: discharging a patient at times clinical stability is secured. As a result, it is rational to conclude that discharge is an inherent part of the emergency scheme under Article 27 of the Motor Vehicle Against Third Party Risk Proclamation. In relation to this, "clinical stability ready for discharge" refers to a condition where the patient's vital signs are found to be within an acceptable/normal range after blood tests and medical condition.[123] According to the Admission and Discharge Protocol for Ethiopian Hospitals, a patient is 'fit for discharge' if s/he no longer requires emergency medical treatment within a secondary care setting, as an inpatient, and where:[124]

- ✓ "review of the patient's condition can be shared with the appropriate health professional including adjustments to medication;
- ✓ ongoing general, nursing, and rehabilitation needs can be met in another setting at home, in those cases where applicable, or through primary/community/intermediate/social care services, and;
- ✓ additional tests and interventions can be carried out in an outpatient or ambulatory care setting."

The other type of secondary transfer is referral. In this respect, referral is recognized under various laws in the country. First, the Food, Medicine and Health Administration and Control Proclamation requires medical institutions to administer secondary transfer/referral to the appropriate health institution where a person under emergency medical condition cannot get the proper treatment in the medical institution due to the institutions lack of competence.[125]Moreover, the Regulation that followed it requires medical institutions to effect the referral in accordance with the referral directive. To this effect, the Ministry of Health has come up with a mandatory Referral Guideline that every medical institution should observe. According to this Guideline, before referral the referring medical institution's personnel need to ascertain that referral is necessary for the benefit of the patient.[126]Accordingly, referral is said to be necessary when transferring the victim to another medical establishment is a must in order to stabilize him/her. The referral in this regard

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[123] Admission and Discharge Protocol for Ethiopian Hospitals, p. 11.
[124] *Ibid.*
[125] Food Medicine and Health Care Administration and Control Proclamation, Article, 38(2); Food Medicine and Health Care Administration and Control Regulation, Article 54(2).
[126] Referral Guideline, § 8.1.

could be vertical, horizontal or diagonal.[127] Moreover, the medical personnel that decided the transfer should know where to refer the patient.[128]S/He can do this by cooperating with the referral coordinator found within the medical institution.[129]In due course, the referral coordinator should ascertain that the receiving institution has the capacity to administer effective stabilization within its capacity.[130]In addition, s/he should contact the receiving institution and secure its consent and convenience of admitting the victim in that institution for emergency medical treatment.[131]In other words, the referral should be named to a specifically named medical institution, and also the willingness of the admitting institution should be secured before transfer. The referral medical institution cannot make the referral in a "To whom it may concern/ To any" manner. Above all, the receiving medical institutions cannot refuse such referral as long as it is capable to treat the victim, and has available personnel and space to admit the emergency patient/victim.[132]Lastly, once the referral hospitals personnel secures the consent of the receiving institution, the practitioner who recommended the referral should fill the referral form,[133] secure the consent of the victim for the referral,[134] and refer him/her to the receiving medical institution. The Referral Guideline further requires the

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[127] A referral is said vertical if it is made in a hierarchical arrangement of the health services from the lower end of the health tier system to the higher ones. That is if it is directly made from Health centers to General Hospitals , or when it is directly made from General Hospitals to Specialized hospitals. On the other hand, it is said horizontal when it is made between medical institutions found in similar level for reasons of facility in the interest of patients for cost, location and other reasons. Moreover, a referral is diagonal when a lower level health facility directly refers patients to a specialized facility without necessarily passing through the hierarchical system. This is the case for instance when the referral is directly made from health centers to specialized hospitals. *See,* Referral Guideline, p. 4.

[128] Referral Guideline, § 8.

[129] Referral Guideline, § 9.

[130] Medicine and Health Care Administration and Control Regulation, Article 54(4).

[131] Medicine and Health Care Administration and Control Regulation, Article 54(4); Referral Guideline, § 8.

[132] Medicine and Health Care Administration and Control Regulation, Article 54(3); Referral Guideline, § 9.

[133] The referral form is found attached to the Referral Guideline.

[134] Medicine and Health Care Administration and Control Regulation, Article 52. In fact, at times securing the consent of a victim that sustains motor vehicle accident is not possible. Moreover, at times s/he may refuse to consent for referral. However, though this is the case, the referral could be effected if, either the consent is given by his/her representatives. Such representative could be appointed by law, agreement or court order. In addition to this, at times delaying referral would cause irreversible damage to the victims health the medical institution may refer him/her without securing his/her consent.

referring medical institution to facilitate the transportation of the victim under emergency medical condition.[135]

However, both primary and secondary transfers are not sufficiently utilized in Ethiopia. Due to this, patient dumping is being witnessed in government owned medical institutions.[136] The fear of law enforcement agencies about the fee that would be charged in privately owned medical institutions is affecting the scheme. While there are sufficiently equipped privately owned medical institutions near accident sites, law enforcement agencies are transferring victims to distant government owned medical institutions.[137]Moreover, the fact that the Referral Guideline is not sufficiently publicized and which the resulting lack of awareness about the obligation of medical institutions and their employees' obligation to give emergency medical treatment is seriously affecting the enforcement of the scheme.

3.4 Obligation to Accept/Admit a Transferred Patient

An obligation to admit a transferred patient follows an obligation to transfer. As a result, an obligation to accept a transferred patient includes admitting both primary and secondary transfers.[138]Admitting a primary transfer involves admitting a victim under emergency medical condition while s/he is transferred from the sight of accident.[139] On the other hand, for the purpose of emergency medical law, secondary transfer refers to transfer from one medical institution to another through referral.[140] Nevertheless, in all times, it is effected in order

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[135] Referral Guideline, § 8.2.

[136] An interview with Ato Tilahun Melaku, *supra* note 95.

[137] *Ibid.* For instance, through qualifying the transfer requirement into *"transfer to a nearby institution"* it is possible to avoid a transfer to distantly located medical institutions while there a nearby medical institution capable of treating the victim. Otherwise, transferring a patient to a medical institution located far without justification is equivalent with denial of treatment. Furthermore, in order to protect the financial interest of privately owned medical institutions the lawmaker allows secondary transfer only to government owned medical institutions. Through this it balance the interest of victims with profit making objective of privately owned medical institutions.

[138] Bitterman, *supra* note 59, pp. 103 and 110.

[139] *Ibid.*

[140] Referral Guideline, p. 4. Moreover, referral is defined under Social Health Insurance Scheme Council of Ministers Regulation No. 271/2012 . Article 2(5) of the Regulation provides that referral system means transferring a patient from one health facility to the next higher level health facility. But this definition is narrower. This is because referral could also

to secure the best interest of the patient.[141] Hence, if there is an appropriate transfer made in accordance with the procedure described in the previous section, the medical institution is obliged to accept a victim. However, this does not mean that a patient whose transfer is not appropriate is not eligible for treatment at the medical institution where the transfer is made. As a rule, the institution towards which the transfer is made should treat a victim whose transfer is not appropriate.[142] After treating the victim, the admitting institution is entitled for a remedy against the institution that made inappropriate transfer. Such remedy could be sought through patient anti-dumping provisions.

In Ethiopia, medical institutions obligation to receive a referred victim under emergency medical condition is recognized under the Food, Medicine and Health Control and Administration Proclamation, its subsequent Regulation and Ministry of Health Referral Guideline. The Regulation obliges every medical institution to admit a patient sent to it in accordance with the referral system, and confirm the same to the sending medical institution.[143]In this regard, the Guideline issued by the Ministry of Health provides a mandatory framework regulating the scheme. Though it is referred to as a Guideline, the Ministry issued it as a directive and it is also functioning as a binding directive. According to this Guideline, in case referral is requested by the transferring medical institution, the receiving institutions referral coordinator should promptly consult the request,[144] inquire the necessary information about the medical state of the victim to be transferred and promptly admit the victim in case the referral request is proper facilitate the admission without delay.[145]At this juncture, it is important to note that the referral is said to be proper when the referral by the referring medical institution is justified as well as when the receiving medical institution has the capacity and space to admit the referred victim.[146]

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be effected among medical institutions found in the same level as it is indicated in the Referral Guideline.

[141] Bitterman, *supra* note 59.

[142] *Ibid.*

[143] Food, Medicine and Health Control and Administration Regulation, Article 54(3).

[144] Referral Guideline, § 8.4 and 8.5.

[145] Referral Guideline, § 8.5.

[146]Food, Medicine and Health Control and Administration Regulation, Article 54(2), (3) and (4) Cumulative with the Referral Guideline, § 8.5.

4. Conclusion

Ethiopia adopted a law that entitles all victims of motor vehicle accident a right to emergency medical treatment to the maximum of ETB 2,000. This right is further extended through various legislations that give right to emergency medical treatment for all persons under emergency medical condition. In this respect, the proper explanation of the right includes the right to get appropriate medical screening, stabilization and transfer.

Nevertheless, in Ethiopia we do not have an in-depth analysis and description of the obligation of medical institutions and their personnel. Moreover, these specific obligations are found scattered in various legislations and in the professional codes and norms of the medical profession. In other words, the obligations are not comprehensively stated in one single document addressed. This, has limited the extent to which the public is aware of the obligation of medical institutions and their personnel. Furthermore, due to their fragmentation, provisions that constitute the scheme and the fact that the scheme is not comprehensive have made it difficult to understand rights and obligations related to the scheme. The scope of emergency medical treatment is also not plainly determined. Even more, due to lack of publicity, medical institutions and other stakeholders do not know the presence of the Referral Guideline and the Health Protocol that regulates the scheme. The existence of this Guideline comes as a surprise even for experts at the Ministry of Health, including the legal department. Some experts at the Ministry did not know the presence of the Guideline and the exact obligation of medical institutions. On the other hand, due to the dispersed existence of the relevant provisions, it has become hard to understand the relationship between the Motor Vehicle Risk Against Third Party Proclamation and other related legislations, such as, the Food, Medicine and Health Control and Administration Proclamation and the Referral Guideline. Lastly, though the Referral Guideline and the Protocol are said to be binding documents by the Ministry of Health, they have not went through the exact procedure for issuing a directive. Their nomenclature also does not indicate that they are directives. Thus, it seems that the two documents have not attained a status of directive proper.

Consequently, the author is of the opinion that Ministry of Health and the Insurance Fund Agency should come up with a comprehensive directive that regulates emergency medical condition and treatment. Through such directive, it is possible to properly explain the procedures that should be followed in emergency medical treatment. In due course, the directive could further provide a clearer demarcation of the scope of emergency medical treatment, and the relationship of the Motor Vehicle Risk Against Third Party Proclamation with other legislations. Moreover, the Ministry and the Agency should design and launch an effective awareness creation campaign about emergency medicine and the law. In addition, it is better if the government revisits the limit it provided on the right to emergency medical treatment that is currently set at ETB 2,000 under the Motor Vehicle Risk Against Third Party Proclamation. In this respect, it would be better if the government provides stabilization as a requirement than limiting the scope of emergency services through monetary terms.