Articles

Child Protection in Tasmania

In 1972 a committee was set up in Tasmania by the then Attorney-General "to coordinate the activities of persons or bodies in any way involved with children under 7 years of age who had suffered or were suspected of having suffered non-accidental physical injury arising out of the wilful act or omission of any person or persons caring for them". This Committee, called the Childhood Injury Investigation Committee, was composed of a wide range of people professionally involved with the care of families and children.

Experience in Tasmania and in other parts of the world has shown very clearly that failures in communication between those trying to help families which are surrounded by problems can have very serious consequences. There have even been cases in other countries where children have died as a result of maltreatment, even though they and their families were well known to various welfare agencies and were even being visited from time to time. It was partly in order to eliminate these failures of communication that the original committee was set up.

The Committee did a great deal of useful work, but it operated under difficulties. Not having been set up by Act of Parliament, it had no statutory powers. It could not compel anyone to carry out its orders, it had to depend entirely on persons voluntarily notifying cases, and it was very difficult to manage cases arising throughout the State by a Hobart-based Committee. It also could not require children to be taken to hospital for examination or ensure that cases

It was, therefore, replaced in January, 1975 by the Child Protection Assessment Board. This was set up under the Child Protection Act of 1974, and today has the overall responsibility in this State for the protection of children up to the age of 12 years from physical abuse.

Under its statutory powers, the Board has appointed upwards of 50 authorised officers throughout the State. Anyone who has grounds for believing or suspecting that a child has been injured non-accidentally may report to an authorised officer and certain classes of persons who habitually have the care and custody of children are required by law to report such cases. Anyone reporting voluntarily or by requirement of law is protected from any action for defamation or any other type of action for damages in respect of such report. The

report is also entirely confidential and no person may be required to give evidence in Court on the contents of the report. The authorised officers have powers enabling them to ensure that a child suspected of having been ill-treated is to be admitted to hospital straight away for full medical examination. Simultaneously the authorised officer informs the Board and it arranges for a social worker to investigate and report to the Regional Committee. In this way speedy assessment of the medical and the social welfare sides of the case is possible, and the Regional Committee can take on the management of the case with full medical and other information regarding both the child and the family.

It should be stressed that the object of the Child Protection Act and of the Board is not to punish, but to help. In fact, there is no mention whatsoever in the Child Protection Act of any penalties at all. The Act is concerned with removing children from situations of actual or potential danger. Sometimes this means taking children out of their home for a time, but the aim is always to restore children to their parents as soon as it is safe to do so.

To oversee the ongoing assessment and rehabilitation of families which come to its notice, the Board has set up Regional Committees in Hobart, Launceston, Burnie and Devonport and, if necessary, these will be extended to other areas. These committees are composed of the people professionally involved with families which are surrounded by problems, and include among their members, doctors, nurses, welfare officers, guidance officers, probation officers and social workers. Representing as they do a wide range of professions, organisations and Government departments, the committees reduce the communication problems which can be so troublesome, and enable an overall view of the case to be assessed without any undue emphasis on any particular aspect.

In recent years much publicity, some of it frankly sensational, has been given to the problem of non-accidental injury to children. It should, however, be stressed that many of these unfortunate occurrences are the result of pressures, frustrations, overwork, social or housing conditions which would try the patience and self-control of most of us, and it is unfair in most cases to regard the parents as criminals or monsters. The Child Protection Assessment Board and its Committees are mindful of this, and consequently their concerns are protection of children and rehabilitation of families. Retribution and punishment is no part of their task.

In the first 12 months of the operation of the Child Protection Act, over 40 cases were referred to the Board.

Research has conclusively shown that a proportion, probably as high as one quarter, of severely battered children are permanently affected in some way, and that battered children grow up to be battering parents. With sufficient effort and skill, this vicious circle can, however, be broken.

The study of non-accidental injury to children is a comparatively new field, and it has taken time to work out and set up the necessary administrative and other machinery to operate the Act, and also for all concerned to develop special skills in diagnosis, assessment, and treatment. There is, however, plenty of scope for further development, now and in the foreseeable future, and we recognise this and are planning accordingly.

Whilst within certain statutory limitations we feel that our measures for child protection are functioning fairly well, we cannot afford to be complacent about this extremely important issue, and are constantly striving to improve the services which we can offer families and children. We are concerned as a high priority with working out educational and other preventive measures so that we can tackle the question of child abuse at its source and not merely after the abuse has occurred. We are seeking amendments and improvements to the existing Child Protection Act to enable us to undertake these additional functions. Provided we are given the necessary statutory powers, we hope to be able to improve very considerably on present services.

W. H. Goudie

Legal Abortion Services in Canada

Legal Abortion Services in Canada

Late in September 1975 a committee under Sociology and Behavioural Science Professor Robin F. Badgley was established through the Federal Justice Minister "to conduct a study to determine whether the procedure provided in the [Canadian] Criminal Code for obtaining therapeutic abortions is operating equitably across Canada". Canadian abortion law at that time was under critical scrutiny, but the committee was required to "make findings on the operation of this law rather than recommendations on the underlying policy". Accordingly, the Badgley Committee, in its 474-page Report on the Operation of the Abortion Law released in February 1977, refrained from legal analysis, and simply recorded practice on availability of abortion services, and attitudes that influence availability.

It was all too obvious, even before the Committee was established, that the only answer to the question whether the procedure for abortion was operating equitably across Canada was that it was not. Both proponents and opponents of easier abortion provisions agreed that particular availability was governed more by geography and economic means than by an abortion applicant's medical con-

dition. The *Morgentaler* cases (see B.M. Dickens "The *Morgentaler* Case: Criminal Process and Abortion Law" (1976) 14 Osgoode Hall Law J. 229) had shown the obstacles to access to facilities for termination of pregnancy in Montreal, a city well served with hospitals. Successive juries had acquitted Dr. Henry Morgentaler of performing abortions in breach of conditions laid down in the Criminal Code, on the ground that it had been necessary for him so to act to preserve his patients' health because prompt and affordable hospital abortion services were inaccessible.

The Badgley Committee has detailed the facts and dynamics of inequality in access to abortion services in Canada, and tells a tale on which stronger conclusions can be based than appear in the Report. Committee members were faithful to the constraints limiting evaluation of existing law, but also diluted their observations in order not to attract vituperative criticism from pro- and anti-abortion factions. Neutrality was further assisted, and compelled, by the two Committee members serving with Professor Badgley being associated with factions opposing each other.

Understandable though restraint in evaluation of the law may be, one may nevertheless regret that the Committee failed to undertake necessary legal analysis. No hint appears in the Report of the *Morgentaler* judgments that revealed the potential for lawful abortion outside the machinery provided by the Criminal Code. The Committee's references to illegal abortion are thereby rendered less convincing, since Dr. Morgentaler's services might have come within their concept of illegality even though the courts had defined circumstances in which they could amount to legal abortion. A more important oversight, however, is that, while the Committee dealt fully with termination of pregnancy, they entirely disregarded the problem of its commencement.

Abortion was treated as arising after pregnancy is established or reasonably suspected, but certain contraceptive means take effect before this stage is reached. Intrauterine devices in particular seem to operate by preventing implantation of a fertilized ovum (See V. Tunkel "Modern Anti-Pregnancy Techniques and the Criminal Law" [1974] Criminal Law R. 461), and both pre- and post-coital drugs may operate contraceptively upon such ova to obstruct their biological progress. The use of these techniques of fertility control is likely to grow with developments in prostaglandin and other "morning after" treatments and post-coital menstrual extraction. Religious doctrine, especially that of the Roman Catholic church, is inclined to hold pregnancy and ensoulment to occur upon fertilization of the ovum, not at the later stage of implantation, and accordingly would consider loss of the fertilized unimplanted ovum as abortion. The Canadian Criminal Code provides for up to life imprisonment for use of any means for illegally procuring another's

abortion, but no longer condemns making available means of contraception. It would seem important to know the difference.

The law

The Criminal Code provides in s. 251 that procuring abortion (the Code speaks only of "miscarriage") is illegal unless undertaken by a qualified medical practitioner acting in an accredited or approved hospital after the hospital's therapeutic abortion committee has certified that in its opinion "continuation of the pregnancy . . . would or would be likely to endanger [the female's] life or health". The physician must not be a member of a therapeutic abortion committee for any hospital, and a committee must have not less than three members each of whom is a qualified medical practitioner, and may decide by majority. It follows that a hospital must have a minimum number of physicians to operate provisions of the Criminal Code, but that it is not compulsory for a qualifying hospital to establish a committee. While an "accredited hospital" is so recognized by the Canadian Council on Hospital Accreditation, an "approved hospital" receives its status under rules established by its provincial Ministry of Health.

Findings

The Committee found that many physicians and nurses, to say nothing of patients, did not know the terms of the abortion law, and on being questioned revealed significant misapprehensions as to its provisions. It was found that "lack of knowledge or inaccurate knowledge about the law poses a major dilemma in how its procedures operated in practice" (p. 66). Nevertheless, the Report records an analysis of the Committee's findings on provisions made for lawful abortion, and attitudes held in the medical, nursing and wider communities. The committee's major findings of fact were that "the procedure provided in the Criminal Code for obtaining therapeutic abortion is in practice illusory for many Canadian women" (p. 141), and that "the criteria used by hospital therapeutic abortion committees across Canada were inequitable in their application and their consequences for induced abortion patients" (p. 279).

Provision of abortion services. Of all civilian hospitals in Canada in 1976, 20.1 percent had established a therapeutic abortion committee. Of hospitals that conformed to requirements of eligibility to perform therapeutic abortions, whether set by their provincial Health Ministry or otherwise, 48.5 percent had a committee in existence in 1976. There was, however, no uniformity across the nation in standards of medical care or facilities required for eligibility of general hospitals, and a facility qualifying in one province might fail to qualify in a contiguous province. Two out of five

Canadians did not live in communities served by hospitals eligible to establish committees.

Hospitals equipped with committees often imposed internal rules to prevent accommodation of abortion patients coming from outside the area they attempted to serve with their full range of facilities. For instance, some reserved their treatments in favour of women who had resided in that area for a given time before applying for therapeutic abortion, and others set a periodic quota for these operations, to preserve a balance with their other procedures. The Badgley Committee found that "the combined effects of the distribution of eligible hospitals, the location of hospitals with therapeutic abortion committees, the use of residency and patient quota requirements, the provincial distribution of obstetrician-gynaecologists, and the fact that the abortion procedure was done primarily by this medical specialty resulted in sharp regional disparities in the accessibility of the abortion procedure" (p. 28).

The response that services should be more uniformly available may be resisted, however, since to spread operations more evenly, perhaps in proportion to the source of requests for them, may increase complication rates. The Committee found that specialisation, associated with concentration, increased proficiency, and that "the hospitals performing the largest number of abortions had the lowest complication rate in spite of performing a larger number of abortions, in the later stages of gestation" (p. 29). The committee accordingly favoured concentration of performance of abortion procedures in regional centres with a full range of required equipment and facilities, staffed by experienced and specially trained nurses and medical personnel. Such centres could also serve to relieve pressure on general hospitals whose staff were reluctant to engage in these procedures.

Delays. Safety in abortion is associated with the patient's stage of gestation, and the Committee favoured making abortion available at the earliest stage possible. It was found that on average, women took 2.8 weeks after first suspecting pregnancy (not after *becoming* pregnant) to visit a physician, and that after this the average interval was 8 weeks until the induced abortion operation was done. The delay resulted from the manner in which physicians, hospitals and abortion committees dealt with applicants. Among women pregnant 16 or more weeks (that is, well into their second trimester), one in five had no therapeutic abortion committee in her local community hospital. Physicians' unawareness of the length of delay in delivery of abortion services was apparent in their responses to the national survey of physicians undertaken by the Committee; only one out of 200 reported the average length of time between initial consultation and performance of the abortion procedure to be eight weeks.

There were found to be two related further effects of delay. A woman going through the abortion committee process and being

refused would find a procedure in the United States more difficult, both to experience and to afford; and commercial referral agencies arranging abortion in U.S. clinics, if they actually disclosed that abortion is legally available in Canada, pointed to the delays involved, in order to make their alternative appear more attractive and its cost worthwhile.

Therapeutic abortion committees. The Badgley Committee was unable to comment upon the aspect of the functioning of abortion committees the lawyer would find most disturbing, namely the complete absence of any entitlement of applicants to due process. Provision exists in the Criminal Code for a provincial Health Minister to receive a copy of a certificate authorising an abortion, together with such other information relating to its issue and the procedure conducted under it as he may require, although no Minister appeared ever to have taken this initiative. There is no provision, however, for a Minister, an applicant, her physician or any other person to receive grounds of refusal of an application.

The need for means to question decisions (other than by application to another committee) may appear from evidence of committee requirements. The formula of the Criminal Code must be observed, of course, but many committees impose additional and at times idiosyncratic demands. A number has residence tests, quotas and gestational limits, but beyond that many had a series of further requirements. Two-thirds (68.4 percent) of committees required consent of the woman's spouse if she was married, and one out of five (18.4 percent) required this even if the couple was separated or divorced. Some committees required consent of the male responsible for conception even if the woman had never been married.

The legal defensiveness of these requirements is obvious, but they may appear to make poor social sense. If a couple is agreed as to the procedure, for instance, the male's consent adds nothing, and if they are disagreed, perhaps endangering the future stability of the relationship, it may be oppressive to the female to afford the male the means to prevail. Further, by withholding consent, a spouse might compel continuation of his wife's pregnancy by another man, leading to birth to a wife he might leave of a child he might have no obligation to support. In any event, since abortion can be done only when "continuation of the pregnancy would or would be likely to endanger . . . life or health", creation of a veto power in a spouse or less closely related person may appear unjustifiable.

Related to provincial laws on the age of majority, it was found that "there was a diversity of consent requirements relating to the age of the woman and to [consent of] the father" (p. 238). The age of consent to medical treatment appears to range from 14 in Quebec to 19 in some Maritime provinces, even though the general provincial age of majority may be higher; in Quebec, for instance, it is 18. This leaves open the way to uncertainty, since some committees observe

the age of consent to medical treatment (in Ontario, for instance, 16), while others in the same province observe the general age of majority (in Ontario it is 18). Below the age of majority or medical consent, which may be above the age of marriage, the position is even less certain since the girl's parents may disagree as to therapeutic abortion, and a spouse or other male causing the pregnancy may himself be a minor.

Reasons upon which abortion committees have allowed abortions are not more satisfactory. The Criminal Code accommodates no eugenic indication for abortion, such as gross abnormality of the fetus, nor a juridical indication of rape or incest. Nevertheless, in 87.7 percent of hospitals, the possibility of deformity or congenital malformation of the fetus was considered in review of a pregnant woman's history, and "pregnancy resulting from rape or incest was a consideration given high priority by therapeutic abortion committees, most of which (80.6 percent) considered their occurrence as valid reasons for the approval of a therapeutic abortion" (p. 265). Many committees considered in addition the effect of continuance of a woman's pregnancy on the health of her family, the economic implications of pregnancy, its extramarital origin and her age if below 18 or over 40. A majority, however, (68.5 percent) was not prepared to support an application solely on the grounds of terminating an out-of-wedlock pregnancy.

Professional attitudes. Among doctors in the national physician survey, the issue of therapeutic abortion cut across all social backgrounds and types of medical practice experience. Almost half feel that induced abortion lowers the value of human life, and when physicians of this persuasion constitute a majority of an eligible hospital's medical staff, their views significantly determine the hospital's position on whether to set up an abortion committee and provisions under which an existing committee operates. Conversely, almost half of the physicians in hospitals without committees said they would be prepared to serve on such a committee if it were established. Generally, however, the hospital's position reflects the majority view of its physicians.

The decision of two-thirds of eligible hospitals without committees was based on grounds of religious morals and professional ethics. A quarter of such hospitals are owned by or affiliated with religious denominations, and rather than become involved in abortion procedures they express a preference to change ownership, to close or to transfer their services to other patient treatment programs.

Most hospitals reported no recent problem involving staff recruitment for abortion services, but one out of six hospitals did not employ staff who felt unable to provide care for all patients. Evidence exists that some, though few, nurses feel and express hostility to abortion patients, and penal attitudes have been demon-

strated in the rare practice of showing the patient the aborted fetus.

Recourse to the United States. About ten thousand Canadian women a year (about one in six having abortions) have recourse to U.S. facilities, and commercial and other referral agencies are available to ease arrangements. Some commercial agencies misrepresented both Canadian law and the actual costs involved in proceedings in Canada. The Committee found reasonable doubt about the propriety of their work, but that "they existed because there was a demand for their services which was not otherwise being met" (p. 386). Non-profit voluntary associations have been active over several decades, however, in arranging procedures, although this is seldom their central purpose. Of community agencies and branches of the Planned Parenthood Federation of Canada (used by just over 7 percent of patients surveyed) 66.1 percent at least occasionally referred women to U.S. facilities, the rate for agencies in Ontario, Quebec and the Maritime provinces exceeding 80 percent. Of such agencies, 75.8 percent recommended this course if a woman's application had been refused by a Canadian abortion committee.

The legality of access to out-of-country facilities was confirmed in the third *Morgentaler* trial, when prosecuting counsel asked Dr. Morgentaler why he had operated in Montreal when he could have referred his patients to U.S. facilities. Acces to the convenience of such facilities is limited, of course, to those able to pay the travel and treatment costs involved.

Birth Control. A major thrust of the Badgley committee's findings is towards better spread and use of information on contraception, and the Federal Health Minister's immediate response to the Report was to give undertakings, including on diversion of funds, to promote better birth control information. The Committee found that "a sizeable number of Canadians have had no formal instruction on the use of contraceptive means; the physician is seen as the chief source of such information for women and men; and learning about these methods from all other sources is very much a hit-or-miss affair" (p. 367). Other sources included schools, churches, community agencies and public health departments. Notably absent from mention as a source of information were newspapers, radio and television (see B.M. Dickens "Eugenic Recognition in Canadian Law" (1975) 13 Osgoode Hall Law J. 547 at pp. 554–5). Ironically, it was found that "in its work abroad Canada has helped to initiate on a cooperative basis with other nations the components of a comprehensive family planning program. This endeavour stands in sharp contrast to the efforts in these respects which have been undertaken in this country" (p. 419).

More public money is spent on providing treatment services and facilities for abortion patients than on the public effort to undertake effective preventive measures. The Committee found that the

options are few concerning induced abortion. There is no evidence that its volume is decreasing and, indeed, its reported incidence has increased in recent years. The critical social choices are between the two sensitive issues of induced abortion and family planning.

The Committee considered the evidence conclusive, and found that when effective contraceptive means are appropriately used, the chances of conception occurring are sharply reduced, if not eliminated, for most women. The extent of induced abortions in the future can be expected to remain the same as at the present time, and it may gradually rise, unless there are effective changes made in the contraceptive practices of Canadians. Made in the context of known family planning and population policies, these changes may be brought about by increased efforts through research to find more effective and acceptable methods of contraception and by coordinated programs of public education and health promotion. The Badgley committee warned that "there is no surety that such steps will be fully effective, but without taking them, there is virtually no likelihood that the volume of induced abortion will be reduced, or even contained at its present level" (p. 377).

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1979 Commonwealth Medical-Legal Workshops

Reports have now been published of medical-legal workshops held in 1979 in Barbados (June) and Malaŵi (October). The workshops were organised by the Commonwealth Secretariat and in response to a suggestion made by Commonwealth Health Ministers when they met in Wellington, New Zealand in 1977. Funded by the Commonwealth Fund for Technical Co-operation, and with a substantial contribution from the International Planned Parenthood Federation each covered the same set of issues and considered discussion papers which covered—

(a) legislation on the use of paramedicals for primary health care;
(b) legislation on commercial advertising inimical to health;
(c) the law on medical termination of pregnancy, and related issues; and
(d) legislation on medical drugs.

Participants were enthusiastic, and universally agreed that joint exercises of this kind were invaluable, holding the potential (in fact

realised at Barbados and Blantyre) of making significant and tangible contributions to the well-being of their publics. All left with a heightened and informed consciousness both of the problems and of their own role in meeting them: and all were pledged to ensure that the momentum created by the workshops be not lost. Follow-up strategies were given special considerations.

The conclusions reached in Barbados were as follows—

Legislation on the use of paramedicals for community health care

(i) Governments could usefully review the legal arrangements which affect the training, authorisation, practice and supervision of paramedical personnel, as a means of nationalising the delivery of primary health care services.

(ii) Such an examination should ensure that where the roles of paramedical personnel are expanded, such personnel are afforded appropriate legal protection.

(iii) Where new cadres of paramedicals are created, or where it is found that cadres are functioning without appropriate legislative recognition, these personnel should be given legal status.

(iv) It is timely for the roles which traditional practitioners play in the delivery of health care to be reviewed, and, where appropriate, the limits of their practice should be regulated.

(v) The establishment of regional advisory groups should be considered, to study the question of the role of paramedical personnel in the delivery of primary health care.

(vi) These groups could explore ways in which regional co-operation might be undertaken in this connection.

(vii) These groups could also consider such matters as setting standards and harmonising the selection, training and supervision of paramedicals throughout their respective regions.

(viii) The Secretariat should continue to act as a conduit for information and documentation on the use of paramedicals in primary health care.

(ix) The Secretariat should continue to support efforts to establish a medical-legal dialogue on the use of paramedicals in the delivery of primary health care.

(x) The Secretariat should provide, on request, appropriate technical assistance to Commonwealth governments in connection with the use of paramedicals for primary health care.

Legislation on commercial advertising inimical to health

(xi) Governments should consider establishing appropriate machinery to enable physicians, lawyers, public administrators and policy-makers to tender joint advice on measures to control advertising inimical to health.

(xii) Governments should also consider undertaking broad and aggressive educational programmes, using all available means of

public communication, in conjunction with the adoption of such legislation as may be necessary to control the advertising and use of products inimical to health.

(xiii) Governments and health professional associations should consider taking all possible steps to prevent the use of health professionals, and persons posing as health professionals, to promote the sale of products inimical to health.

(xiv) Regional machinery should be established to examine the practicability of regional measures for the control of both direct and indirect advertising inimical to health, to promote intergovernmental and multi-disciplinary discussion of the problems, and to facilitate the exchange of relevant information.

(xv) The Secretariat should collect legislative and educational material from member countries and elsewhere, to assist governments to control the advertising and use of products inimical to health.

(xvi) The Secretariat should take such steps as are necessary to provide member governments with information on the effectiveness of both direct and indirect advertising of products inimical to health.

The law on medical termination of pregnancy and related issues

(xvii) The material before the workshop, and the experience of participants, suggested that existing laws in many countries may be out-dated and in some instances may create health risks. Where this situation exists, legislative reform is the only remedy. The options which emerged were simple repeal, which may be unacceptable, or the introduction of an advanced law. Those concerned with the drafting of advanced laws could learn from the experience of countries which already had advanced laws, and in this way avoid repeating some of their faults.

(xviii) It was desirable for the legal formalities in advanced laws to be kept to a minimum, to allow procedures for termination at the earliest possible stage of pregnancy.

(xix) Notwithstanding the desirability that termination should be at an early stage, care should be taken to ensure that it is the woman's real and considered wish that her pregnancy should be terminated, and also to ensure her protection from undue pressure.

(xx) Consideration might be given to decriminalising abortion during the first twelve weeks of pregnancy.

(xxi) It was considered important that abortion services should be rendered by adequately-qualified, but not over-qualified, personnel. In principle, it seemed that the person providing general health care for the community should be responsible for providing abortion services. If this person were a registered medical practitioner, there did not appear to be any reason why other

qualifications should be sought unless they were required for specialised procedures.

(xxii) Consideration should be given to authorising suitably-trained paramedical personnel to provide early abortion services under appropriate supervision.

(xxiii) It was considered appropriate for abortion for adolescents to be regulated under comprehensive provisions for fertility control and education. Ideally, parental concurrence should be sought, but when this is not available or is refused and the minor seeking abortion is left in jeopardy to life or health then naturally the patient's interests should prevail. In such cases there might be an alternative source of permission: perhaps the minor and her physician might have immediate access to an independent public officer, such as an Official Guardian or Children's Ombudsman, to present evidence and apply for legal authorisation by this officer *in loco parentis*.

(xxiv) In the case of adult patients—and also minors, subject to (xxiii) above—it was seen as desirable to minimise the need for third-party consents in legislation. Most participants felt that only the informed voluntary consent of the patient, competent to give consent, on whom the procedure is to be performed should have to be obtained.

(xxv) Pending possible implementation of an advanced law, measures should be considered which would ease physicians' fears of acting under existing laws. These could include the development of a check-list of items which physicians could show they had taken into account in their decisions, in order to demonstrate their good faith. Emphasis on physicians' good faith directed to the welfare of patients might do much to remove the criminal taint from abortion procedures.

(xxvi) It was desirable that providers of health care who claim conscientious objection to being involved in abortion should be required to refer patients to personnel or agencies known not to be averse to the procedure. However, the workshop saw no room for conscientious objection in cases of emergency or post-abortion case.

(xxvii) Ideally, abortion services should be rendered in facilities offering general female health services, sterila sterilisation and breast self-examination.

(xxviii) Consideration should be given to accommodating abortion primarily in laws focusing not upon crime and punishment but upon health and welfare.

(xxix) A continuing dialogue should be maintained between doctors and lawyers on the impact of legislation upon medical practice, and the impact of medical technology upon the relevance and application of laws.

(xxx) National documentation of proposals for legislative

reform and copies of legislation enacted should be sent to the Commonwealth Secretariat, in order to ensure that other jurisdictions might benefit from collective experience in this difficult field.

(xxxi) Regional groups of countries should explore the possibility of regional collaboration to improve the legal availability of abortive services, to make means of fertility control more freely available, to determine the appropriate qualifications of paramedical personnel involved, and to clarify and, where necessary, reform relevant legislative provisions, including those concerning adolescents. The provision of a consultant, on request, to assist governments of the region in this connection, and to advise on how recommendations of the work-shop might be implemented, should be considered.

(xxxii) Regional groups should also promote the training and monitoring of appropriate health care providers, on a regional basis, in the light of the workshop's recommendations.

(xxxiii) The Secretariat should, where requested, assist in whatever way it can governments and regional groups seeking to implement recommendations of the workshop.

(xxxiv) The Secretariat should, from time to time, circulate to member governments documentation on proposals for legislative reform and copies of relevant national legislation. A periodic listing of relevant health legislation in the Commonwealth should also be made available, possibly by extracting references and citations from the Commonwealth Law Bulletin.

(xxxv) The Secretariat should seek to arrange further workshops and continue to promote discussion to improve understanding between doctors and lawyers on abortion, contraception, adolescent health care and associated matters.

Legislation on medicinal drugs

(xxxvi) Governments should consider establishing national and/or regional panels of experts to keep under constant review the technical aspects of drugs and the complex and multi-sectoral issues involved in their importation, use, distribution and quality control.

(xxxvii) Governments should consider providing opportunities for the medical and legal profession to exchange and review on a regular basis information on relevant issues, and to plan appropriate national and joint policies, and action on them.

(xxxviii) Those governments that have not yet signed the International Convention on Psydiotropic Substances are urged to give favourable consideration to doing so.

(xxxix) The Secretariat should where possible assist member countries, on request, to convene regional meetings and discussion groups in relation to (xxxvi) and (xxxvii) above.

(xl) The Secretariat should continue to collate and distribute to

member countries, from time to time, information that might be of value to them in reviewing their national drug policies and relevant legislation.

(xli) The Secretariat should provide member countries, on request, with all possible technical, educational and training assistance in this connection.

Other medical-legal matters of concern

(xlii) The question of compensation for damage arising from a medical accident where there was no negligence should be given further study.

(xliii) The question of difficulties arising in some jurisdictions where professional men and women may be reluctant to give evidence or take action against their professional colleagues should be examined by medical and legal professional associations, so that any public concern which may exist may be removed.

(xliv) Rules of evidence should be kept constantly under review to see how far it is possible, consistent with the imperative needs of justice, for doctors to submit written reports of their conclusions to the courts, subject to the right of the parties to insist upon the appearance to give oral evidence and to be cross-examined.

(xlv) When doctors are summoned to court every effort should be made to ensure that they are away from their essential duties for as short a time as possible.

(xlvi) Whilst it is recognised that the granting of permission to set up "off-shore" medical schools is solely a matter for the sovereign governments concerned, everything possible should be done—nationally, regionally and internationally—to prevent establishment of medical training institutions whose facilities and teaching fall below recognised standards.

(xlvii) The medical-legal dialogue should be continued on a regional basis, and governments should consider setting up appropriate machinery to this end.

The conclusions reached by the Malawi workshop were—

Legislation on the use of paramedicals for community health care

(i) The concept of expanding the roles of paramedicals in providing health care, which involve such functions as simple diagnosis and treatment normally undertaken by doctors, was endorsed.

(ii) The use of paramedicals to perform such functions be encouraged, and that the cadres concerned be given further recognition.

(iii) Governments could usefully review the legal arrangements which affect the selection, training, authorisation, practice and

supervision of paramedical personnel, with a view to improving the delivery of health care services.

(iv) Such a review should seek to ensure that, where the duties of paramedicals are expected to include acts normally undertaken by doctors, the personnel are afforded adequate legal recognition and authorisation. This may mean that some existing laws and regulations will have to be changed.

(v) Where new paramedical cadres are created, or where it is found that existing cadres are functioning without appropriate legislative recognition, these personnel should be given legal status appropriate to their training and their functional roles.

(vi) The role which traditional (folk) practitioners play in the delivery of health care should be reviewed. Where appropriate, standards for their practice should be established, regulated and, if necessary, improved, and the creation of self-regulatory bodies should be encouraged. Folk practitioners should not simply be ignored by the health care establishment; active attempt to encourage their co-operation should be made.

(vii) Before any legislative or regulatory action is taken in relation to paramedicals, a dialogue should be established between the medical and legal authorities within the government, so as to achieve the best possible arrangements. Machinery should be created to ensure that this dialogue should be a continuing process.

(viii) At both national and regional level, the use of paramedicals should be made the subject of continuing study.

(ix) The role of paramedicals in health care delivery should be considered at national health meetings and also at regional meetings of Health Ministers, and that legal personnel should be invited to contribute to these discussions.

(x) The Commonwealth Secretariat should continue to act as a channel for information and documentation on both the medical and the legal aspects of the use of paramedicals in primary health care.

(xi) The Secretariat should continue to support efforts to establish a medical-legal dialolgue on the use of paramedicals.

(xii) The Secretariat should provide Commonwealth governments, on request, with appropriate technical assistance in connection with programmes which seek to make fuller use of paramedical personnel.

Legislation on commercial advertising inimical to health

(xiii) Governments should consider establishing advertising review boards for the purpose of restricting misleading advertising and the promotion of products the use of which is detrimental to health.

(xiv) Governments should also explore the possibility of estab-

lishing codes of ethics or standards by legislation, for advertising and promotional activities relating to all products and particularly to those inimical to health.
(xv) Governments should consider promoting health education in every way possible, using all available means of public communication, to counteract the advertising and use of products detrimental to health.
(xvi) Efforts should be made on a regional basis to achieve uniformity in codes of ethics and standards established for advertising, and to promote inter-governmental and multi-disciplinary discussion of the problem and co-operative action.

The law on medical termination of pregnancy and related issues
(xvii) Present laws on the medical termination of pregnancy are often unclear, to the detriment of women's health. It was considered desirable for every jurisdiction to have at least a developed law, either by legislation or through an authoritative executive statement of the scope of lawful abortion under the existing law.
(xviii) Laws were found to fail to accommodate recent medical advances. It was considered that laws relating to approved contraceptive measures should be clearly exempted from the scope of laws relating to abortion.
(xix) It was thought that indications for lawful abortion should include, at the minimum, preservation of life and physical and mental health, as determined necessary in good faith by a doctor. These indications could cover a number of other, more specific indications, although the case for separate inclusion of these should be considered.
(xx) It was recommended that consideration should be given to accommodating abortion primarily in laws focusing not upon crime and punishment but upon health and welfare.
(xxi) Persons performing lawful abortion were considered to be best protected by a clear statement of the legality of procedures performed in good faith on medical (and specified non-medical) grounds.
(xxii) Qualifications of persons authorised to perform abortions and the facilities to be used should be determined with reference to prevailing local circumstances. Provisions should be flexible, offering the best possible health care in the circumstances and not insisting on standards unnecessarily made higher than those for other comparable medical procedures.
(xxiii) The study of why abortion procedures needed to be differentiated in law from other health-directed medical procedures was recommended.
(xxiv) Approval procedures for abortion, and also the scope of any third party veto, should be related to the woman's health

care needs in her prevailing circumstances, and should not prejudice her welfare.

(xxv) It was thought that too little was known by the authorities in many countries about the extent and the circumstances of abortion. It was therefore recommended that governments should arrange for the systematic gathering of relevant data.

(xxvi) In all cases of medical termination of pregnancy the woman should be given, or at least offered, the means of contraception and instruction as to use, where available and acceptable.

(xxvii) The Commonwealth Secretariat should encourage discussion of issues relating to the medical termination of pregnancy at meetings of Commonwealth Health and Law Ministers, and at regional and national level.

(xxviii) The Secretariat should continue to act as a channel for information and documentation on both the legal and the medical aspects of the medical termination of pregnancy.

(xxix) The Secretariat should continue to support efforts to establish a medical-legal dialogue on the subject.

(xxx) The Secretariat should, where possible, provide technical assistance to Commonwealth governments requesting help with the development of their laws on the medical termination of pregnancy.

Legislation on medicinal drugs

(xxxi) Each country should have a national formulary, based on the local disease pattern, and this formulary should be used as a basis for bulk purchase and quality control.

(xxxii) There should be a clear national policy, backed by appropriate legislation and regulations, on the importation of drugs, including imports for use by the private sector, based on local requirements and designed to keep costs down.

(xxxiii) Adoption of a limited list of drugs could be effective in reducing costs. Full information on the drugs listed should be made available to persons responsible for ordering them.

(xxxiv) Training curricula for doctors and other medical staff should include teaching on prescribing and the economics of drug purchase, and should place emphasis on treatment with the cheaper drugs.

(xxxv) A national policy on the control of advertising and all other forms of drug sales promotion was seen as essential. Close consultation between medical and legal authorities is needed in this connection.

(xxxvi) Steps should be taken to educate the public about the use and abuse of medicinal drugs. This process would be facilitated if a limited list of drugs was used.

(xxxvii) The organisation of medical stores is often unsatis-

factory and needs improvement, especially where stocks of commonly-used drugs are concerned. Close co-operation between doctors and pharmacists is essential and care should be taken to avoid excessive ordering. Adequate training for medical store staff is also required.

(xxxviii) In view of the various pieces of legislation dealing with drugs, medical and legal authorities should together examine what consolidation is required and should together initiate action to secure this.

(xxxix) Governments should provide the Commonwealth Secretariat with copies of recent legislation concerning medicinal drugs, for collating and distributing to other member countries.

(xl) Groups of neighbouring countries should create machinery to keep all aspects of the supply and use of drugs under constant review, and to promote practical co-operation on a regional basis. Legal, as well as medical and pharmaceutical, staff should be involved in this process.

(xli) Regional schemes for joint purchase, manufacture and quality control of drugs should be undertaken where practicable, in the interests of economy and the maintenance of drug standards. An appropriate mixture of manufacturing in the region and importation from outside could be worked out, and the required legal provisions made.

(xlii) The Commonwealth Secretariat should, where possible, assist member countries requesting help with the improvement of drug supplies and control, and should continue to encourage regional co-operation to this end.

(xliii) The Secretariat should continue to collate and distribute to member countries information, including copies of legislation, that may be of help to them in reviewing their national drug policies and legislation.

The Reports of both Meetings are available on application to the Medical Division, Commonwealth Secretariat, Marlborough House, Pall Mall, London SW1Y 5HX. They include the following papers—

(a) Para-Medicals in primary health care: Medical-legal issues and alternatives, by Dr. Francis M. Shattock;
(b) Legislation on commercial advertisers inimical to health, by Lorne E. Rozovsky; and
(c) Law on medical termination of pregnancy, by Rebecca J. Cook and Bernard M. Dickens.

The following studies, published separately by the Commonwealth Secretariat, were also considered by the workshops—

(a) The use of paramedicals for primary health care: a survey of medical-legal issues and alternatives, by John M. Paxman, Dr. Francis M. Shattock and Prof. N.R.E. Fendall (£3); and
(b) Three studies of abortion laws in the Commonwealth: Develop-

ments in medical technologies for fertility regulations and their implications for medical legislation, by Mostyn P. Embrey; The law against family planning—a Commonwealth survey, by Victor Tunkel; and A survey of abortion laws in the Commonwealth, by Rebecca J. Cook and Bernard M. Dickens (£3).

Communiqué of 1980 Meeting of Commonwealth Law Ministers

1. The Meeting of Law Ministers of the Commonwealth opened at Sam Lord's Castle, Barbados, on 29 April 1980 with an inaugural address by the Chief Justice of Barbados, the Rt. Hon. Sir William Douglas, and concluded on 2 May 1980.

2. The Meeting was attended by Law Ministers, Attorneys-General, other Law Officers and officials from 41 countries, and elected as its Chairman, the Hon. Henry de B Forde, SC, Attorney-General and Minister of External Affairs for Barbados. Those participating on the first occasion since attaining their independence included Dominica, Kiribati, St. Lucia, St. Vincent and The Grenadines, and Solomon Islands. All were congratulated on their achievement of nationhood, and these joined in the special welcome which was extended to Zimbabwe as it took its place at the Commonwealth table for the first time.

3. Ministers expressed their very great indebtedness for the scholarly, perceptive and helpful papers prepared for the Meeting.

4. They reaffirmed their conviction that the Commonwealth association, committed as it is to guaranteeing the rights of all and to upholding the Rule of Law, and with its shared legal heritages, provides a firm foundation for the highest level of co-operation and mutual assistance in the legal field. This did not circumscribe participation in other international fora, in which Commonwealth members have traditionally played a role, nor did it limit the extension of co-operative arrangements to jurisdictions beyond the Commonwealth.

5. In the course of their deliberations, Ministers reviewed a number of areas in which special intra-Commonwealth arrangements have functioned well to the mutual advantage of the peoples of the Commonwealth, and considered ways in which existing levels of co-operation might be even further enhanced.

Recognition and Enforcement of Judgments, etc

6. The Meeting recognised that the ability to enforce judgments and certain other court orders, and to serve process, across

jurisdictional boundaries was of the greatest importance, particularly in times of ever increasing mobility and in the wake of the shifts of population that have taken place over the past 40 or so years. For

Human Tissue Transplants

22. A number of Commonwealth jurisdictions have, in recent years, sought to regulate the removal and use of different types of human tissue from both living and dead donors. Ministers recognised that sensitive moral, ethical, religious and legal issues were involved, and a variety of approaches was canvassed in their discussions.

23. Ministers considered it important that unsatisfactory procedures should not be permitted to develop. While a humanitarian approach to the problem was being pursued, they were also anxious to prevent any commercial exploitation of donors. They agreed to keep each other informed, through the Commonwealth Secretariat, of future developments in their jurisdictions, and supported the suggestion that the Secretariat consider organising a combined medico-legal workshop to further discuss the matter.