

III. Legislation and the Medical and Health Care Professions

A. An Overview

The principal sources of regulation of the health care professions are the statutes on the practice of medicine, nursing and midwifery, the rules promulgated pursuant to them and the public health statutes and regulations. These statutes, rules and regulations for the most part define who can do what and under what conditions. They define, either explicitly or by inference, the practice of medicine, nursing and midwifery, and limit the right to engage in practice to licenced or registered individuals.(18) For paramedical personnel, as well as physicians, the areas of practice in which they may engage are sometimes quite explicitly specified; more often than not they are vague, with the crucial question of what one may do being derived from the profession one is licenced to practice.

The usual statutory formula is to grant to a central council or government agency various powers, including the right to set the criteria for registration of individuals for practice, to accredit training institutions and to license health care facilities. Although licensing may not be required for a particular category of health personnel, certification or registration usually are. Indeed, registration may be viewed as a form of licensing. Administrative and procedural schemes for licensure, certification, and/or registration are prescribed by statutes or by regulations promulgated by the controlling agency.

Actual accreditation of training programmes and certification of personnel usually are administered by authorized non-governmental agencies, such as associations of medical professionals, pursuant to statutes or regulations or by government ministries.(19). It is the task of these associations or public agencies to establish minimum curriculum requirements for the schools, detailing the subjects to be taught and the practical training that must be experienced. They establish the content of the syllabi. They also formulate the qualifying examinations which each candidate must pass before being certified for practice. Where nursing or midwifery councils are established, it is usually required that practitioners register with the council.(20) This may be automatic upon passing the required qualifying examinations.

B. Definition of Medicine and the Medical Practitioner

If the solution to the dilemma of primary health care were to be found merely in deploying the health professions rather than in defining roles and functions, the question of what constitutes, in legal terms, the practice of medicine would not have to be answered. Everyone would simply continue doing what they are doing now, and there would be no need of looking for potential legal problems. But re-deployment is not the solution. Re-definition of roles is. Therefore the question is of interest.

The answer is of initial importance for at least four reasons. First, by defining the nature of medical practice, statutes may set out the types of activities which are ostensibly reserved to doctors.

Second, statutes may also contain language which will help decide which types of personnel are authorized to perform certain functions. Third, the statutes give us some understanding of the legal nature of the practice into which paramedical personnel, arguably, may be encroaching if, as is advocated here, they begin to take on expanded roles in the delivery of health care services. And fourth, the statutes specify the sanctions against those who engage in the unauthorized practice of medicine. The first and fourth are of particular interest.

Laws regulating the practice of medicine are universal. The rationales behind their enactment are essentially two-fold. On the one hand, they provide medical practitioners with a legally protected existence. On the other, they seek to protect the public from quackery and other forms of unqualified medical practice. In addition to hinting at what constitutes the practice of medicine or, more precisely, who may practice, the statutes normally create some sort of organizational basis for controlling medical practice. This is achieved by granting a number of specific powers to a Medical Council (or some other similarly titled body), including the powers to set educational, examination and licensure standards for doctors and to devise the rules of practice.

In order to complete the puzzle of what is meant by the practice of medicine and who can practise, it is sometimes necessary to put fragments of several sections of the laws together. Even so, the puzzle is often left incomplete. There is no definition of what acts constitute the practice of medicine in the Kenya statute. Perhaps none is to be expected. Section 2 of the Medical Practitioners and Dentists Act, 1977, does, however, define a medical practitioner as "any person registered under this Act as a medical practitioner". To qualify for registration (21) one must demonstrate that he holds a "degree, diploma or other qualification" which is acceptable to the Medical and Dental Practitioners Board, has "engaged in training employment in a residential medical capacity" for not less than one year, has "acquired sufficient knowledge of, and experience in, the practice of medicine" and that he is a "person of good moral character and a fit and proper person." We are left to ponder what the "practice" of medicine really is. (For a copy of the entire Kenya Act see Annex A).

"Medicine" is defined in the Medical Council Act, 1973 (Bangladesh) as "modern scientific medicine and includes surgery and obstetrics".(22) That statement is no less indefinite but it does narrow the field somewhat. To register as a medical practitioner in Bangladesh one must possess "recognized medical qualifications", and satisfy the Medical Council either that he has been employed in a "resident capacity" in an approved hospital or institution or has similar work experience which has provided him with "experience of the practice of medicine, surgery, obstetrics and gynaecology."(23)

The Medical Ordinance in Sri Lanka defines a medical practitioner as one "recognized by law as a practitioner in medicine or surgery. . . by modern scientific methods".(24) To be recognized he must be registered. Every practitioner is entitled to practise medicine and surgery (25) and recover charges for his services.(26) One must search the legislation in vain for more specific definitions as to what "medicine and surgery" are.

The legislation in St Kitts is a bit more definite. Section 24 of the Medical Act states that a person may register to practise "if he can demonstrate that he holds a medical or surgical degree or diploma" and that "he is of good moral character". This gives him the right to give medical advice, perform surgical operations and prescribe or supply medicine and treatment for a fee.(27) No other person is legally authorized to do that. There is, however, no clear statement of what types of work are covered by these words. Indeed, none is really possible. The list would be too long to make any sense. For the most part what is "practice" must be inferred from the statute. It simply is whatever doctors are trained to do generally. Specialists must have further specific training, but in some instances no further registration need take place.

The Medical Profession Act of Saskatchewan makes a more comprehensive attempt to define the "practice" of medicine. There, Section 69 reads as follows:

Every person shall be deemed to practise medicine within the meaning of this act who holds himself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, disability or physical condition, or who offers or undertakes by any means or methods to diagnose, treat, operate or prescribe for any human disease, pain, injury, disability or physical condition.

Such a statement paints with a rather broad, if not vague, stroke the acts which are considered to be the practice of medicine. But it is more specific than most statutes in the Commonwealth.

The words "diagnose, treat, operate or prescribe" make up the magic formula defining the broad activities which go to make up the practice of medicine. These are the acts which the law recognizes as "doctors' work". Yet, the words themselves are seldom defined with any exactitude. As one writer has said: "The practice of medicine is defined broadly enough to apply to witch doctors, voodoo 'queens', or the pharmacists who suggest aspirin for a headache.(28) In the course of providing medical care it is not uncommon to find paramedical personnel performing functions which could be construed as being characteristic of one or all of the four. To a large extent, the task of discerning whether paramedical personnel have stepped over the line into the practice of medicine has been left either to the courts or to the professional licensing bodies. Some have been more certain than others in declaring when the line has been crossed, but the dividing line has generally consisted of "diagnosis" or "treatment". But for the most part they have reserved their sanctions for the so-called exploitive "quacks", a distinction often being made between limited practice and quackery.

When it comes down to detail, it may be quite easy to identify some breaches of the medical practice statute. The act of prescribing drugs is a case in point. The doctor's authority to prescribe drugs is buttressed by the pharmaceutical laws and regulations: under usual conditions only medical practitioners can write prescriptions. Non-doctors who attempt to prescribe may be said to violate the law, unless new legal arrangements are made.

Medical practice then enjoys a rather broad application. In its simplest terms medical practice may be said to apply to all those activities undertaken within law that are necessary to alleviate illness and return the patient to a state of health. It involves making judgements and preferring treatment.

C. Traditional Medical Practitioners

A brief word is appropriate here on the subject of traditional medical practitioners. They have a role to play in primary health care and beyond. Because of the multi-cultural makeup of their populations, some Commonwealth countries permit a multi-tiered system of medical practice to exist. Alongside the modern Western-orientated medical practice, forms of traditional or indigenous medicine are tolerated, and sometimes actively encouraged. Some of these are given statutory recognition. Under such a system, the traditional "physicians" are authorized by law to practise the form of medicine in which they are specialized. This recognition is often contained in the medical practice statute.

1. Indigenous therapeutics

For example, the Malaysian Medical Act of 1971 includes provisions which exempt from the sanctions imposed on those caught in the unauthorized practice of medicine those persons who practice "therapeutics" according to purely Malay, Chinese, Indian or other native tradition.(29) The Kenya statute governing medical practitioners likewise protects the "practice of systems of therapeutics according to African or Asian methods".(30) But the practice must be geographically confined to the community to which the practitioner belongs, and "native doctors" are specifically forbidden to give injections.

By virtue of the provisions of the Medical and Dental Decree 1972, the practice of indigenous systems of therapeutics in Ghana is subject to the following restrictions: (1) that the practitioner be an indigenous inhabitant of Ghana; (2) that no act be performed that is dangerous to life; and (3) that no restricted drug be prescribed, supplied or administered by him.(31)

2. Ayurvedic medicine

The traditional ayurvedic physicians in Sri Lanka are controlled by a special registration act (32) and come under the authority of the Ayurvedic Medical Council. The scope of their practice is considerably wider than that of other traditional practices mentioned in the preceding paragraph. In addition to being able to register as "general practitioners", they may render special treatment in nine categories:

snake bites and other poisons; fractures and dislocations; eye diseases; boils and carbuncles; children's diseases; mental diseases; skin diseases; ailments or diseases associated with pregnancy and childbirth; and hydrophobia.(33)

Similar legal arrangements exist in India where it is estimated that there are some 200,000 registered practitioners of Indian medicine -- including the Ayurvedic, Unani and Sidha systems of medicine. In

addition some 200,000 traditional Ayurvedic practitioners practice in rural areas who are neither qualified nor registered. These have received in-service training from their preceptors. Those practitioners who are institutionally qualified, usually employ modern drugs to treat acute conditions. There are two major aspects to Ayurvedic medical practice - preventive and curative. On the preventive side three components are dealt with: personnel and social hygiene, the use of rejuvenating measures to prevent ageing and decay and the practice of Yoga. On the curative side treatment includes administration of medicine internally, application of medicinal preparations externally, surgical measures and treatment by psychosomatic measures.(34)

The contribution which traditional practitioners can make to a nation's health care system may often be overlooked in the rush to "Westernize" medical and health care. Traditional practitioners, located as they are among the rural populations, may be the most effective purveyors of health care available. To the extent that they are, it might not be wise to displace them. Statistics from India indicate that there are some 400,000 of these practitioners; only half of these are "qualified and registered". Those who are not may be subject to the same types of legal problems that affect other paramedicals.

D. Nurses

Nursing is one of the health care professions which has for years enjoyed statutory protection. To a degree the aims of such laws are similar to those of the medical practice statutes, that is they are designed to give the nursing profession legal status and they seek to ensure that only qualified nurses practice, hence protecting the public from sloppy, inexperienced care. The usual scheme of things is to establish a Nursing Board or Council whose duties include maintaining a "register of nurses".(35) Such a Board may also be empowered to establish the conditions for registration, to conduct examinations, to set criteria for curriculum content, to accredit nursing schools, to establish rules of nursing practice and to establish disciplinary committees. In some Commonwealth countries, as a matter of law, some of these functions are carried out by the Minister of Health.

1. Registration

Of key concern here are what must be done to qualify for registration, what types of registers are kept and what can those who are registered do? One is qualified, indeed entitled, to register upon completion of the required training courses and upon passing the required examinations. In some countries a minimum age requirement also exists.(36) In others there is a requirement that the person be "of good character".(37) To register or enrol, as the case may be, in New Zealand, an individual must satisfy the Council "that he has undertaken the nursing programme and passed the examinations prescribed".(38) It is the registration which gives the individual the "licence" to practice. That is one form of legal protection.

Because of the nature of paramedical legislation nursing councils may keep several types of registers or rolls. These may cut across the paramedical cadres. The Indian Nursing

Council is empowered to maintain "a register of nurses, midwives, auxiliary nurse-midwives and health visitors".(39) Of great importance also in India are the State registration acts. The one for Uttar Pradesh, on whose register nurses, midwives, assistant midwives, health visitors and auxiliary nurse-midwives may be found, is typical. The major prohibition in the Act is that no person, unless registered, may hold an appointment at an institution which receives public funds. In Barbados separate "registers" must be kept for nurses and midwives and a "roll" for nursing assistants.(40) The distinction between "registered" nurses and "enrolled" nurses is a common one. (See Annex B for an exemplary statute).

2. Rules and regulations

The authority of nurses to provide health care is derived from the fact that their name appears on the register. Registration verifies that they have been properly trained and qualified for practice. The limits of that authority are simply not to be found in legislation on nursing. While legislation is the point of departure, in most Commonwealth countries statutes are rather general, indeed one may search in vain for a definition of what "nursing" is.

The statute in Quebec is the exception. Nursing is defined as

Every act the object of which is to identify the health needs of persons, contribute to methods of diagnosis, provide and control the nursing care required for the promotion of health, prevention of illness, treatment and rehabilitation, and to provide care according to medical prescription....(41)

The definition takes on interest when compared to the discussion of medical practice.

Few statutes in the Commonwealth are specific in expressing what a nurse may do. That is left for elaboration in the rules and regulations. In most cases it takes the combined reading of legislation, Ministry of Health regulations, nursing rules of ethics and rules of particular hospitals to get a full picture of what a nurse's rights, duties and responsibilities are. It is not uncommon to find among the regulations relating to nurses long lists of "shalts" and "shalt nots". It is to these that we look for some hint as to the limits of nursing practice. (See Annexes C and D for examples).

Regulations on the practice of nursing in Ghana, for example, contain three specific categories of "treatments" which may be performed: 1) those which may be performed "without instructions" from a doctor, 2) those which may be performed only on written instructions from a doctor but not necessarily in his presence; and 3) those which may be performed only on instruction and in the doctor's presence.(41a) Nurses are authorized to administer common drugs for relief of pain without a doctor's order. They may administer other drugs only if ordered to do so by a registered medical practitioner. On instructions they may perform minor operations and suture wounds. They are not

authorized to prescribe drugs. This is a normal rule. (See Annex D for a complete list of rules applicable in Ghana). Any deviation from that practice would have to be justified, as in the case of an emergency, or sanctioned. Indeed, usually nurses are permitted to give medical treatment without medical orders only in emergencies. Essentially their job is to carry out physicians' orders. The rules and regulations of the Government and Nursing Council of Uttar Pradesh set out limits of nursing as follows:

"2. The duties of a nurse shall be confined to nursing a patient. She shall not assume the role of a medical practitioner." (emphasis added).

In addition the rules state that:

"5. None of the persons registered under this Act are entitled to grant any medical certificates or any certificates of death or still birth."

3. Rule-making power

It is at this point that we begin to see how the laws and regulations affect what roles nurses can legally undertake in the context of primary health care. At the same time we have some indication that regulations are susceptible to change. The rule-making power of the Ministry of Health or the various councils concerned with paramedicals is of no little consequence. Many of the adjustments which need to be made in redefining what paramedicals may do can be made short of reforming legislation if this power is used. This may have to be done in consultation with some facets of the medical profession but where, as is the case in Barbados, the General Nursing Council has the authority to make rules "regulating and redefining the nature of services to be performed by nurses, midwives and nurse assistants" there is wide scope for re-vamping the functions. In Bangladesh it is the Government who holds the power to "regulate, supervise and restrict within due limits the practices of registered nurses, midwives and health visitors".(42) Section 39 of the Nurses and Midwives Decree (Ghana), 1972, grants to the Commissioner for Health the authority to make regulations concerning the "practice of nurses and midwives".

In India the Council has little authority in matters relating to nursing practice, though it has adopted rules which establish an ethical framework. The rule-making authority rests principally upon the State nursing councils and individual hospitals. These usually regulate the roles of nurses through standing orders.(43)

Standing orders also figure quite prominently in setting out the functions of midwives and health visitors rules of practice in India and cover such items as use of drugs, definition of abnormal conditions suitable for referral and treatment of minor ailments. Standing orders for the auxiliary nurse-midwife in primary health care are issued by the Medical Officer or the public health nurse in India and authorize such tasks as treatment of minor ailments and distribution of drugs.

E. Midwives

Much of what was said of nursing laws and regulations holds for midwifery, as in the Commonwealth both practices are often covered in the same piece of legislation. In many ways midwives have more authority than nurses in providing certain types of health care. Yet the exact extent of their "practice" varies according to the regulations which define the scope of their activities. In Australia, nurse-midwives are forbidden to supervise a pre-natal patient in the absence of authority from a medical practitioner.(45) Moreover, the regulations stress that they must work with a practitioner and carry out his instructions.(46) This doctor-midwife relationship is a common feature of midwifery legislation.

1. The "province" of midwifery

The Western Australia statute contains a rather blanket prohibition, as do other laws, against a midwife involving herself in "any treatment of a patient which is not properly within the province of a midwife".(47) This "province" in terms of time runs from the commencement of a pregnancy to a few days after delivery. As nothing is said in the act or regulations which could reasonably be viewed as authorizing an expanded health care role for the midwife, if she were to do anything like that she would surely run afoul of the law. A "narrow view" of midwifery, derived from the language in the laws, may well preclude midwives from providing any useful form of extended health services, as a fortiori they would call outside the time span during which midwifery can, legally and practically, be practised. It is difficult to hold to such a narrow view though. Given the pace of developments in midwifery practice the "province" is clearly subject to expansion.(47a) Expansion of midwifery roles to include family planning is an example. It is, of course, accepted that midwives may undertake procedures, if requested by their medical colleagues, provided they have been properly trained.

Midwifery laws and regulations do, however, permit midwives more authority than nurses usually possess. They can, for example, prescribe and handle various drugs which facilitate their work. In the United Kingdom Rule 5B of the Midwifery Rules states that a midwife "must not on her own responsibility use any drugs. . .unless in the course of her training. . .she was thoroughly instructed in its use". It is common for a midwife to carry with her the following drugs and preparations: antiseptics, aperients, sedatives and analgesics, ergot and agents for resuscitation. In addition, certain drugs, normally available on prescription from a doctor, may be supplied by a midwife in the UK according to Part III of the Medicines Act.(48) Similar rules apply in Kenya.(49) Again, any expansion of the roles which midwives fulfil in providing health care would have to be buttressed by appropriate changes in the regulations if not in legislation.

The law does permit midwives an expanded power in an "emergency." This is a commonsense approach and is reflected in many regulations. In Australia nurses involved in midwifery are required to "forthwith" call in a medical practitioner if

an emergency arises. Where this cannot be done, however, the midwifery nurse is authorized to "take such action as she considers advisable in the interests of the patient or child".(50)

2. Traditional midwives

In many Commonwealth countries there are large numbers of "midwives" practising outside the law. These are the traditional birth attendants (TBAs)* who initially acquired their skills by delivering babies themselves or by working with other traditional birth attendants.(51) These midwives have no legal status, though they can be found practising in small outlying villages in all developing countries. In that setting the authorities are of little interference. Malaysia attempted to register all and train some TBAs within the country in the early 1970s. But a decision to try and replace them with government midwives halted their integration into the health service scheme.

F. Medical and Health Auxiliaries

Auxiliaries are a subordinate, yet essential, category of health personnel. Compared to nurses and midwives, they usually have less formal education, less health care training and may be given less legal authority to undertake primary health care tasks. Their status is mirrored in the laws and regulations which control their activities. To this extent, expanding the roles they take in providing primary health care may involve legal problems that are somewhat different from those of nurses and midwives; in other ways the problems are quite similar.

The usual legislative pattern which pertains to auxiliaries is to have them register with the professional body which regulates their speciality, i.e. the Nursing Board or Midwifery Council. These professionals tend to control their practice. For example, the Nurses and Midwives Decree in Ghana stipulates that auxiliary nurses may perform "services of an elementary nature", (52) as permitted by the Nursing Council, but that they must work under the supervision of a registered nurse or midwife. Fair enough. In Barbados a nursing assistant, as a matter of caution and common sense, is prevented from undertaking any duty or carrying out any procedure "for which she has not been trained".(53) But she is covered by legislation.

Some "medical auxiliaries" essentially operate without legislative protection. The medical assistants and rural medical aides in Tanzania are two such types. Some medical assistants there, however, are given an additional 18 months of training. Once the course is completed they become licensed medical practitioners and are registered under section 19 of the Medical Practitioners and Dental Ordinance. On the other hand, under recent arrangements all medical assistants in Fiji will be given statutory protection for the exercise of their craft under the recently enacted Medical Assistants Act, 1978. Under the new legislative scheme medical assistants may "practice medicine"

* These are known variously throughout the Commonwealth as dais, kampong bidans, granny midwives and wakunga.

if "only in the service of the Government". The Minister of Health possesses the authority to establish the "conditions and restrictions" under which they practice.(54) Other matters, such as registration, are handled by the Medical Assistants Registration Council.(55)**

Despite being "one step removed" from the practice of medicine, auxiliaries do have a vital role to play in the provision of health care. One initial problem is to see to it that they have appropriate legislative protection. Beyond that one must look for ways to use this cadre more rationally.

G. Summary

The current legal situation relating to paramedical personnel may be generalized* as follows:

Medical practice laws, with rare exceptions, either implicitly or explicitly, make examination, diagnosis, prescription and the supervision of treatment and surgery the special prerogatives of doctors. Unauthorized involvement in these duties by non-doctors, as we will see more clearly in the next section, is punishable under the law.

Nursing legislation and regulations require in the main that nurses act subject to the instructions and under the supervision of a medical practitioner. Thus, they may not by themselves take the initiative in providing many types of primary health care services. The same may be said of other nursing and health care auxiliaries.

At present, midwifery legislation defines the practice in such a way that the provision of some primary health care services, especially those relating to family planning, are not to be found among the authorized duties of a midwife.

Thus, without some other form of specific authorization, paramedical personnel do not have the legal authority to provide many of the types of services which would be counted as part of primary health care. The same is true for other types of non-doctor personnel for whom no legislation exists.

* We do so notwithstanding the dicta offered by Blake that "to generalize is to be an idiot". We take comfort though in the fact that someone else once wrote, "The world is full of facts which have no meaning unless they can be summarized into generalizations for common guidance".

** See Annex E.