

## VI. Legal Alternatives for Expanding the Roles of Paramedicals in Primary Health Care

Given the present state of affairs it is impossible to consider providing primary health care to the populations of most Commonwealth countries without first considering expanded roles for paramedical personnel. As we have seen there is considerable variation among nations in the use of paramedical personnel. Some of this variation corresponds to variation in statutory law, some to differences in regulations. Even where two or more countries have essentially the same statutory law, as is often the case in the Commonwealth, the regulations issued under the authority of the law which outline which tasks paramedicals may undertake differ considerably. The roles which paramedicals are permitted to play are also affected by the regulations issued by associations of health professionals and by health care institutions or by the personal preference of doctors and health care administrators. There are essentially two "models" which exist.

Restrictive roles. This model reflects the conventional approach to health care delivery which has the medical practitioner performing most primary health care tasks. Paramedicals play a supportive role but the stark distinction between the practice of medicine and other health care practice is maintained. The roles which paramedicals take are necessarily restricted. While the model may be appropriate in some settings, depending on resources and manpower, it does seek to provide the highest quality care, in many instances at the cost of reaching only a small portion of the population because the model focuses on doctor-provided care.

Expanded roles. This model reflects an innovational approach to health care delivery which has paramedicals performing many of the primary health care tasks. Paramedicals play a key role in the provision of health services and they assume responsibility for duties normally undertaken by a doctor, particularly routine diagnoses and treatment. The doctor is available for referral care and to handle the more difficult cases. This model seeks to provide health care services to the largest possible portion of the population.

One of the factors to be considered in any attempt to move away from the restrictive model is the law. There are legal alternatives which can aid and abet this shift. Before we discuss those fully a word is needed about the situations which exist in many countries.

Two situations exist with respect to the law. On one hand, it may be common to find paramedicals throughout the Commonwealth providing primary health care for which they are not ostensibly authorized. This is as much a comment on the fact that laws and regulations are outmoded as it is of the fact that the demand for such services has outrun the ability of the legally approved health care system to provide. What happens de facto often bears no relationship to the legal requirements. Practice outstrips the law. This reflects the inability of the law to accommodate the arrangements which the people desire. In this circumstance many people simply ignore the legal requirements and practice outside the law. For example, although

in many countries laws exist for the purpose of controlling the flow of medicines and drugs these are ignored and drugs, otherwise available only on prescription, are available to anyone who wants to purchase them.

From a strict legalistic point of view this is not entirely desirable. It has the disadvantage of creating considerable confusion as it leaves participants without any meaningful legal protection, particularly if what they are doing is clearly prohibited by medical practice or pharmacy or criminal laws.

On the other hand, because the laws are restrictive, when it is suggested that paramedicals undertake a task for which they have no legal authority many wince and refuse. They are schooled, after all, to refuse to do any task which is illegal. So the law at times becomes an impediment even though it protects the status quo. Both of these situations argue for the law and the de facto to find each other. It is for the law to come closer to the de facto rather than vice versa. The experience with abortion is an apt analogue to what must happen over the issues relating to use of paramedicals. The need for abortion services appears to have forced changes in the law rather than vice versa. The same should be true for primary health care and rules relating to how the services are delivered.

That brings us to the legal alternatives for accomplishing this. As far as paramedicals are concerned two major problems exist: 1) legal recognition and 2) legal protection. All of the three alternatives set out below can provide legal protection; only alternatives two and three can provide legal recognition. Those alternatives are:

- 1) Delegation of doctor functions to paramedicals
- 2) Alteration of rules and regulations affecting paramedical practice.
- 3) Legislation in support of paramedical participation.

#### A. Delegation of Doctor-functions to Paramedicals

The doctrine of "custom and usage"(82) has firmly established delegation as a prerogative of a doctor. There are limits though. For example, the medical practitioner must maintain some sort of supervision\* over the personnel to whom he has granted expanded roles and some care must be taken in selecting the tasks to be delegated. But this is an area in which there is legitimate leeway, as experience in a number of countries has shown. Taylor suggests that "those functions that can be easily routinized should be assigned to appropriate trained auxiliaries or paramedical workers".(83) He takes the view that 90 per cent of medical care could be handled in this way. Thus, a doctor may be able to delegate

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\* The concept of supervision is elastic if not elusive. There is some disagreement over the closeness with which supervision is conducted. Some countries are rather rigid, with doctors supervising no more than two paramedicals and literally camping on their shoulders. In other settings the supervision is considerably looser with the doctor some distance away but with contact maintained.

to paramedicals, after appropriate training and with adequate supervision, many health care tasks which he has normally performed himself. Delegation in the areas which involve surgery should, however, be undertaken with some caution. The vital point in this whole area of law is that the physician must ensure that those performing health care tasks under his supervision are suitably trained, for it is he who retains legal responsibility for their actions. This fact may provide one unfortunate result in that the paramedical shoulders no responsibility for his actions and therefore may go about his work with a degree of nonchalance. Where authority is transferred to the paramedical in other ways it is possible for the duties to become part of the paramedicals job description and therefore the onus of liability falls on him. (See discussion of negligence above).

Delegation is not without its problems, however. There are some functions which by law doctors may not delegate. One example is the actual prescription of medicaments. Even so, there are ways to more fully utilize non-physicians. One approach is for a doctor or hospital to issue "standing orders" which establish the instances where paramedicals can perform doctor functions. The delegation approach may be legally unacceptable for primary health care purposes, however, if laws or regulations: (1) forbid a doctor to delegate a function which is inherent to the practice of medicine; (2) require that the task be performed in the "presence" of a doctor; (3) forbid paramedicals to do anything which encroaches on medical practice.

Another limitation is that it depends on the willingness of individual doctors or institutions to delegate. Doctors may be reluctant, for any number of reasons including liability, to use the approach, the result being that public access to health care services remains limited. And uniformity in the training that the paramedicals receive will most likely be lacking. The approach does, however, afford to those doctors and institutions who are interested in increasing the coverage of services the opportunity to achieve some measure of that desire without having to face the problem of trying to promote an outright change in the law. All things considered, in the absence of a total overhaul of the law relating to the utilization of paramedicals, the delegation alternative is both useful and attractive. It has been used to advantage in many countries.

Where there are no doctors present to delegate the idea may be nonsensical. This raises the question though, as to whether paramedicals can delegate to other paramedicals in order to achieve a more rational system of health care delivery. The legal problems are similar. As an example, we turn to the midwifery regulations in Kenya which say that

A midwife must not delegate any part of her duties as set out in these Regulations to any other person except another midwife who has the Local Supervising Authority permission to practice. (84)

Notwithstanding this type of regulation, it is likely that many tasks performed by doctors and paramedicals alike can be "delegated" and in that sense legal protection is afforded. This "cloak of approval" is sufficient for many purposes.

## B. Alteration of Rules and Regulations Affecting Paramedical Practice

Legislation relating to paramedical cadres generally gives the authority to make rules and to regulate the scope of their practice to either the Ministry of Health or the professional council. This is no mean authority. If the desire is to expand the roles of paramedicals in primary health care, one way to achieve this is to make appropriate changes in the rules defining paramedical practice. At present these rules strike a cautious posture. By re-defining paramedical roles the restrictions they now face fall. (See Annex D for a suggested list of tasks paramedicals should undertake in primary health care and a sample list of tasks they are at present authorized to do.) One distinct advantage of this approach is the flexibility it allows.

Changes in regulations may have to be orchestrated with other legislation or regulations. This is particularly true in the case of prescribing and dispensing drugs. But these tensions can be worked out. A number of countries have authorized paramedicals to handle specific drugs through the use of ministerial regulations. This technique could certainly be used to influence change in other areas of primary health care delivery.

Of course, the Minister of Health often possesses extraordinary power in making arrangements for health care delivery. Ministry regulations, irrespective of other legislation, can often establish expanded roles for paramedicals within the health service.

An example of this can be found in Kenya where two sections of the Public Health Act, 1972 can be read in such a way as to give the Minister authority to determine the roles and duties of people within the health service. Local governments with permission of the Minister of Health can appoint local medical officers and assistants under Section 9(1A). But the Minister may "prescribe . . . the duties to be performed" by these personnel, many of whom will be paramedicals.(85) Section 10(2) of the Act establishes the duties of the Medical Department and includes promotion of "the public health and the prevention, limitation or suppression of infectious, communicable or preventable diseases within Kenya". This cannot be done without personnel and as that section also bestows the task of carrying out such a programme on the Medical Department, it has some authority in deciding how this may be done.

Again, standing orders have a key role to play here in establishing practice within the health service. To borrow experience again from the field of family planning, roles of paramedicals have been expanded to include prescription of orals and insertion of IUDs, two functions usually thought of as belonging to doctors, simply by authorizing them to do so once suitable training has been completed. Indeed, in Ghana the roles which paramedicals take in the famous DANFA health care project were adjusted without having to change any legislation.(86)

## C. Legislation in Support of Paramedical Participation

Legislation is essential for the development of the health services and disease prevention programmes. It is just as vital for the success of primary health care programmes. The legal protection of all persons

engaged in primary health care must be ensured, particularly if they are not already covered under the umbrella of existing medical and health legislation. The effectiveness of the paramedical cadres on numerous occasions has been hampered because their legal status has not been explicitly established. And as the "licensing" of all medical practitioners is becoming a more common practice, it is important that the paramedical cadres be established in law as well as in fact.

In a sense one cannot divorce legislation from regulations. Both must be designed to:

1. Provide legal protection for the approved person.
2. Provide the client with an assurance that the procedure will only be undertaken by an approved person;\* and
3. Enable a procedure or procedures to be undertaken.

Several different legislative approaches are apparent.

1. Special licencing or exemption clauses.

Several countries in the Commonwealth have legislation, usually relating to the practice of medicine, which permits the Minister of Health or Director of Medical Services to issue special licences to individuals to "render medical services". These licences carry with them legal protection, or exemption, from the sanctions which could otherwise be imposed. Special exemption clauses are also in evidence. The usual formula is to exempt from sanctions individuals in the employ of government health services or acting under the orders of supervision of a registered medical practitioner. Under such schemes the Minister has ample discretion to define how these individuals are utilized. Where these do exist, the medical practice statutes will not likely have to be amended, though similar clauses could be added to paramedical legislation. As an example which can be adapted, we draw from the Ancillary Dental Workers Act, 1976, of Saint Christopher, Nevis and Anguilla. Section 6 allows that

the Chief Medical Officer, after consultation with the Board may, by authority in writing, permit the performance of any minor dental work of a kind specified in such authority in any part of parts of the State by any person whom he considered to be competent to perform such work, subject to such conditions as the Chief Medical Officer may think fit.

(See Annex D).

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\* Without a doubt this is the most important "design" of laws and regulations. Because of the constructs of our discussion we have not given this the attention it deserves. Legal protection really means nothing if the skills of the paramedical are inadequate.

## 2. Changes in complementary legislation.

Any adjustment in the roles paramedicals take may affect or be affected by other health-related legislation (public health statutes, pharmacy and poison acts, etc.). These may have to be adjusted also to accommodate the new role. But one of the common methods for dealing with this problem is to preface the original change in legislation with the phrase "notwithstanding any legislative provisions to the contrary".

## 3. Legislation permitting delegation of specified duties.

Despite the doctrine of "custom and usage" some doubts exist as to the limits of delegation. These can be resolved by adding a section to the medical practice statute which permits doctors to delegate to other health workers functions they think they are fit to perform. This would remove from the doctors' minds any doubts they may have about delegating.

## 4. Special acts for new paramedical cadres.

The drive to supply adequate manpower for primary health care has led to the creation of several new cadres. Medical assistants are examples. These are essentially outside existing legislation, which at present deals principally with nurses and midwives. These cadres deserve legislative protection of the same order. New legislation would establish a council which would regulate training, qualification, registration or practice. One important benefit of legislation is that it facilitates peer judgement and review. (See Annex E for a copy of a recent statute enacted for this purpose.) Bermuda uses another legislative approach to cover "professions supplementary to medicine" which could be adapted for use for paramedicals. (See Annex H).

## 5. Creation of new registers or rolls under existing legislation.

Legislation which applies to paramedicals requires that registers or rolls be kept on which names of those qualified to practise are listed. Most laws require that separate registers, or parts thereof, be kept for different specialities, and rolls for auxiliaries. This presents the opportunity for creating within the context of that legislation registers or rolls for new cadres, say a primary health care nurse or auxiliary, a child health associate or a family planning nurse specialist. This approach was recently used to create the new cadres of "enrolled nurse" and "enrolled midwife" in Malawi in 1975.(87) A formula should be worked out so that they are represented on the central council and they should have their own special sub-committee or board which controls the issues affecting their practice.(88) It is often impossible for the interests of one group to be safeguarded by another. As many of the paramedicals who are best suited for assuming doctor's functions are the more highly specialized another option is to create a register for post-basic specialities. This is done already in a number of Commonwealth countries.

#### D. General Medical-Legal Considerations

There are, in addition, several considerations which should be taken into account in any legal action to expand the roles paramedicals take in primary health care. These may be recapitulated as follows.

##### 1. Authorization

This is the crux of the problem. Authorization granted to paramedicals should be as direct and specific as possible. We have outlined the various ways that this can be accomplished. But one point merits repeating. Care must be taken to override provisions of the law which limit the roles by either repealing them or making special exemptions.

##### 2. Training

It was the American humourist Mark Twain who said, "You can no more know what you ain't learnt than you can go back to where you ain't been". Many regulations stress that paramedicals may perform functions for which they have received training. Therefore, to say that training is key is an understatement. Many new tasks may be done by paramedicals by simply altering curriculum content. Training should, of course, provide the skills to perform independently as well as to recognize situations where help must be sought from others.

##### 3. Qualification

Requirements relating to qualification seek to ensure that the ability of paramedicals to do what they are trained to do meets acceptable levels. Qualification of those personnel who have already qualified as health workers, (midwife, nurse, auxiliary) should be made contingent on two conditions: (1) that a certified course of training be completed and (2) that some sort of qualifying examination be passed. Those who are currently in training will qualify for expanded roles only if curricula are changed to reflect the change in policy. Other types of paramedical personnel, such as those used in community-based health programmes, should also be considered as being capable of qualifying for authorization, depending on the type of health care they are to provide, once appropriate training has been completed.

##### 4. Supervision

It is widely agreed that the breadth of the work of the paramedical cadres is directly related to the amount of supervision they receive. It cannot be gainsaid that in many of the developing countries the only medical service to the mass of the people is that provided by the paramedical centres. Nor can it be gainsaid that in many of those countries the supervision of such personnel is woefully lacking. Since their performance is directly related to the supervision they receive, it would appear that the whole concept of supervision must be re-examined. There appears to be a very good case indeed for special advisory teams consisting of professional

and paramedical members. There is nothing new in this. Other fields, such as education, utilize supervisors and inspectors much more fully than the health care professions.

The ultimate performance of a paramedical in the field will depend in large part on the degree and quality of supervision under which he is placed. Regulations are required to define supervision, and these must be realistic for the country concerned. Whereas it is possible in a developed country for a paramedical undertaking tasks, such as minor surgery, to be under fairly close supervision of a professional, it is far from the case in a developing country.

#### 5. Referral System

A referral or back-up system to handle complications which the paramedical is not trained to deal with is another aspect to be considered. Whereas training and qualification procedures discussed above are necessary to ensure adequate performance by personnel when they first undertake new responsibilities it is equally necessary to ensure that this level of performance is maintained and that medical care awaits those who suffer complications. No paramedical should be forced to work in isolation. Referral services are essential.

Many proposals to expand the health care responsibilities of paramedicals appear to meet with difficulty because of a concern for the safety of the recipients of the care. The fear is that incompetent care might be provided by paramedical personnel who attempt diagnosis and treatment. This is a legitimate preoccupation. Any expansion of roles of paramedicals must see to the welfare of the consumers and not increase the threat to their health. Properly trained and supervised paramedicals can provide primary health care without increasing the risk to the recipients. On the other side, to enhance the contradictory dilemma, many paramedicals have been trained but have not been utilized because of the legal questions about their authority to do what they have been trained to do.

It is not essential that all of these components be covered in one document, although that has its advantages. The usual procedure is to have legislation which authorizes the training of paramedicals, but leaves the details to further regulation by the Ministry of Health or a professional governing body. Another approach is to amend the medical practice statutes themselves, but that is more time-consuming. Fortunately, in most countries these types of regulatory measures are left to the discretion of the Ministry of Health or a professional governing body. Some very specific and restrictive statutes, however, may need to be amended before paramedicals can be given wider authority, e.g. midwifery laws which specifically state, in an all-inclusive fashion, what midwives may and may not do. Whatever the approach, it is of utmost importance that the new regulations strike down the existing barriers, eliminate the frustrating ambiguities and seek to avoid barriers of an institutional nature which impede the work of paramedicals. One of the tendencies to be avoided in this regard is one which leads to the over-regulation of paramedicals. It will do no good to have one inflexible system replaced by another. Flexibility should be the watchword.