The use of para-medicals for primary health care in the Commonwealth

A survey of medical-legal issues and alternatives

Commonwealth Secretariat

THE USE OF PARAMEDICALS FOR PRIMARY HEALTH IN THE COMMONWEALTH:

A SURVEY OF MEDICAL-LEGAL ISSUES AND ALTERNATIVES

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PREFACE

This survey was undertaken at the request of the Commonwealth Secretariat. It has as its focal point legislation in Commonwealth countries pertaining to the use of paramedicals, particularly in the area which has come to be known as primary health care. The materials upon which the survey was based were supplied by various Commonwealth Governments in answer to a request sent to them from the Legal Division of the Commonwealth Secretariat.

Responses to the survey request were received from the following Commonwealth countries:

Antigua	Kenya
Australia	Malawi
Bahamas	Malaysia
Bangladesh	Malta
Barbados	New Zealand
Canada	St Kitts
Cyprus	St Vincent
Fiji	Sri Lanka
Ghana	Swaziland
Gilbert Islands	Tanzania
Guyana	Tonga
Hong Kong	United Kingdom
India	Western Samoa
Jamaica	Zambia

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The survey aims at analyzing the ways in which various laws affect the roles which paramedicals play in the provision of health services and how these may be altered not only to the benefit of the paramedical providers of primary health care but the recipients also.

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N.R.E.F.

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Introduction

At one point in Through the Looking Glass, Lewis Carroll has Alice complaining incredulously to the Queen about the fact that they seemed to be getting nowhere though the two had been running side by side for quite some time. Befuddled by the turn of events, Alice volunteers that if they had been running that fast in her country "You'd generally get to somewhere else". The Queen is heard to retort, somewhat indignantly, that in her realm one must run that fast just to stay in the same spot. Then she added, "If you want to get somewhere else, you must run at least twice as fast!". The parallels between the scene described by Carroll and what has come to be known as primary health care* are striking. Though programmes around the world have been running for years, the pace has not been such that they have got "somewhere else." There is nothing new in this.

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* There are a number of elaborate yet unsatisfactory 'definitions' of the concept of primary health care. For our purposes primary health care, simply put, is health care which can be diagnosed and treated on an ambulant basis. The words health care, of course, have a very broad application and encompass a number of activities which are easily recognized as health-related. Sanitation and water purification are examples. We will not devote attention to these. Our interest centres on health care given to individuals. As the survey progresses it will become apparent that what we are discussing is, for the most part, the "medical" aspects of health care - "primary medical care" if you will. To crib from the Recommendations of Alma Ata this would involve at a minimum: "maternal and child health care, including family planning; immunization against major infectious diseases;. . . appropriate treatment of common diseases; and provision of essential drugs." Recommendation 5, ICPHC/ALA/CONF.DOC./1 Rev.1, p.9 (1978). The essential characteristics of primary health care are well-established. These are: primary and intimate contact with the community, an adequate range of services, coordination of those services, a capacity for health assessment of both the individual and the community, a continuity of care, a progressive care support structure, a family orientation and a non-institutional outlook. Letter to the Editor (Declaration of Alma Ata, N.R.E. Fendall), Lancet, ii. p. 1308 (1978).

We live in an era of shortages. These affect health care delivery systems as much as anything else. To point out that financial resources are altogether too meagre, supplies too few, services too inadequate and manpower too scarce to meet the minimum health care needs of the people in the world is to repeat what has been said many times before. Because of this, it is ever more apparent that the resources that are available must be utilized with greater efficiency, and in ways which maximize the availability of health care services. In short, not only must the running be faster, it must also be more efficient.

Yet despite the rather gloomy state of affairs there are few who would remark as Alice did when urged to run faster, "I'd rather not try, please!" At long last the world community appears to have recognized this. The recent meeting in Alma Ata on primary health care may be taken as a sign that the world community is prepared to run faster in its efforts to provide adequate health care to the world's population, though the goal set there of "Health for all by the year 2000" will probably remain illusory well into the next century. Goals are one thing; methods of achieving those goals quite another. The strategy developed at Alma Ata on primary health care (1) was prefigured by discussions at the Fourth Commonwealth Medical Conference. There one of the leading papers said of the development of health care programmes:

> First priority should go to the delivery of primary medical and health care at village and neighbourhood level. Much sickness today is relatively easily diagnosed and routinely treated -- indeed in a sophisticated society is self-diagnosed and self-medicated at the local drug store or pharmacy.(2)

It is no secret that much of what is done in the way of providing medical and health care requires, either as a matter of law or practice, the intervention of a doctor. As far as who can do what, legislation in the main is restrictive; it has created a form of closed shop. Yet the use of paramedical* personnel to undertake clinical and other health work, traditionally thought to be the responsibility of doctors, is increasing. The roles non-doctors fulfil are expanding. In many Commonwealth countries this has been recognized as the only practicable way of bringing health services to a greater percentage of the population. These roles are affected, to be sure, by a number of factors-- medical and legal, as well as cultural and political. Any attempt at expanding the roles of paramedicals stands a chance of encountering hindrances of all types. Before the roles are set, these hindrances will need to be overcome. It also carries with it the need, stressed at the Fourth Commonwealth Medical Conference in 1974, to ensure that the personnel involved are afforded the appropriate degree of professional freedom and legal protection, and also that the public are protected against inexpertly delivered health care.

This survey will focus on the types of medical/legal considerations which are sure to affect attempts to expand the roles of paramedicals. It will examine the medical/legal regimes governing the activities of paramedical personnel in such areas as clinical work, obstetrics,

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* For an attempt at a definition as to what is meant by "paramedical", at least within the context of this survey, see below.

minor surgery, family planning, vaccination and immunization, emergency care, the prescription of certain drugs, medical examinations required by public authorities and employers, forensic police work, notification of notifiable diseases and the issue of birth and death certificates. Laws and regulations pertaining to medical and health care practice generally are the principal concern. An attempt will be made to juxtapose the experience of countries with relatively few legal restrictions on the use of paramedical personnel with those of countries with greater restrictions, all with a view to assessing the impact of the different restrictions on the availability of health care. These, in turn, will be evaluated in the light of the pressing need for more extensive use of paramedical personnel. It is hoped that out of these will emerge a list of alternatives for eliminating the harshness of the legal restrictions on paramedicals thereby facilitating the expansion of their roles by providing them with appropriate legal backing. The ultimate goal of such an effort is to enable health care to reach those who are not currently receiving it through those who are not currently authorized to provide it. Some of the latter group may have been trained in various primary health care functions but lack the legal authority to perform them. Both the purveyors and the consumers of health care need protection.

I. Paramedical-- The Search for a Definition

A term which can satisfactorily be applied to the non-doctor cadres involved in health care has yet to be found. Among those often used are "health and auxiliary personnel", "allied health personnel", "non-physicians", "aides", "assistants", "auxiliaries" and "paramedicals".(3) Of these paramedicals appears to be the most widely used, though it is not without its drawbacks. While essentially the term may be applied, loosely, to all non-doctors engaged in health care, some cadres, particularly the nurses and midwives, have objected because they are professionals and hence the term "paramedicals" downgrades them.

The use of the prefix "para" in relation to "medical" is perhaps an unfortunate one, as it connotes "having an ancillary status or function".(4) "Ancillary" itself is defined as "subservient, subordinate".(5) It is also, unfortunately, becoming common to describe these cadres of medical and health workers as "physician surrogates" or "physician extenders". This produces the impression that they are "second best". These impressions are contradicted by current thinking on the subject which looks upon paramedicals neither as subordinates nor as inferior but as important members of the health care delivery team.

As it has been observed:

> Although paramedics were first introduced in some places as second best to the unobtainable fully-trained physician, thinking has now moved away from this in recent years, and paramedicals can now be considered as professionals in their own right, with quite different skills and priorities from those of the doctor. Paramedics are no more second best to doctors than a primary school teacher is second best to the university lecturer, and they have an important role not only in the rural areas of poor countries, but also in the cities and towns of the industrialized areas of the world.... (6) (emphasis in original).

Nevertheless, as we shall see throughout this study, these newer notions have yet to be taken over into the law. It is largely for this reason that this study has been undertaken. The following categories(7) may be regarded as paramedicals for purposes of this study.

1. Health workers with formal training

These workers have had basic education, followed by specific training in medical and health care. The group would be comprised of nurses, nurses aides, midwives, innoculators and other trained non-doctors who work in government and private health programmes. To date their work has been principally urban-oriented in hospitals or clinics and they work under the direct supervision of doctors. More of these personnel are being pushed into rural service where the supervisory lines are extended.

2. Primary health workers

These workers are an emerging cadre. Some are known as auxiliaries. They will have had varying amounts of basic training, but with special training in primary health care, they can return to their communities and make significant contributions to health care. These may either be stationary or itinerant but they focus on villages normally cut off from medical services.

3. Traditional health workers

These are workers who deal with the traditional forms of medicine or health care. The group is composed of such disparate elements as Ayurvedic physicians, traditional birth attendants, bone setters, snake bite specialists and even witch doctors. With the exception of the Ayurvedics, these workers usually lack any form of basic education and most often learn their skills empirically, from personal experience.

As we shall see presently, there exists a great deal of legislation, and regulations, relating to most of the paramedicals in category 1. There are some exceptions, however, and the auxiliary workers are among those. Legislation for category 2 is virtually non-existent, though some regulations may be developing which define what they must do to "qualify" and what types of activities they can undertake. Save for the Ayurvedics (and some other practitioners of indigenous medicines), workers in category 3 practice at the margins of, if not outside, the law. Their speciality is largely "folk medicine" and as such they are not treated as part of the Westernized medical and health care establishment. Not surprisingly no legislation applies to them, except to bar their activities.

The categories of the health service personnel which we place under the rubric of "paramedical" for the purposes of this study are those who do not have full medical qualifications but who may be required to undertake primary health care duties which in the past have been performed only by doctors. Though the list is not complete, such personnel as medical assistants, clinical nursing staff, public health nurses, auxiliary nurses, rural medical aides, maternal and child health staff and midwives are considered "paramedicals" here. The focus of our interest then is essentially non-doctors who are capable of doing "doctor-like" work in primary health care.

The 'paramedical professions' in some countries have taken on quite a different statutory definition. It has come to be applied to persons engaged in such diverse fields as chiropractics, medical laboratory technology, occupational therapy, optometry, opthalmic dispensing, physiotherapy, psychology and radiography.(8) These 'paramedicals' are beyond the scope of this survey. We borrow again from Lewis Carroll who has Humpty Dumpty saying, 'When I use a word, it means just what I choose it to mean--neither more nor less.' In this survey 'paramedicals' means what we have chosen it to mean.

II. The Case for Expanded Roles for Paramedicals

In the past decades gallons of ink have been spilt in articles describing programmes utilizing specially trained paramedical personnel. Out of this mass of literature and experience has arisen a cohesive body of knowledge which demonstrates rather conclusively the practicality of tapping this source of manpower. At the outset, it seems appropriate to rehearse briefly the reasons for expanding the use of paramedicals in primary health care. The general argument in favour of permitting paramedicals to undertake more of the doctor-like responsibilities is as follows:

1. There is need for rationalization in the delivery systems for health care. Though situations differ from country to country, even officials in the so-called developed world have stressed the fact that new and innovative ways of delivering health care services must be sought. It is generally assumed that the basic technology to assure the good health of the population has been developed. What has yet to be resolved in a satisfactory fashion is the question of how to make the technology available to a given populace through an acceptable and effective delivery system. It has been said:

> The major proportion of people in developing countries are not yet aware of health as a concept. What they dimly recognize is the possibility of cure of disease, and secondly, absence of disease. Too many people are born, live and die without ever having the benefit of modern medicine. There is a grave implementation gap throughout the world between our medical knowledge and its application.(9)

The need for pragmatic solutions has often been underscored. One way to accomplish this is to achieve a more rational utilization of existing health resources and a redistribution of manpower roles and responsibilities.

2. There is an acute shortage and maldistribution of medical professionals in most countries. Current tabulations indicate the variances in the doctor per capita ratios throughout the world. Of the Commonwealth countries in Africa, Ghana has one doctor for every 10,510 persons, Kenya one for every 16,300, Nigeria one for every 14,810, and Malawi one for every 48,500. In Asia, Bangladesh has one physician for every 15,050 persons (in rural areas where 90% of the population lives the ratio is one to 30,000), India one for every 4,100, Sri Lanka one per 4,010 and Malaysia one for every 5,600. In the Caribbean the figures fluctuate between one per 3,510 in Jamaica and one per 1,480 in Barbados.(10) These figures may be contrasted with the ratios in the developed world. There is in Canada approximately one doctor for every 580 persons, one per 720 in Australia and one per 700 in the United Kingdom. In some countries the ratio is as disparate for other health professionals. In Bangladesh for example there is one nurse or midwife for 38,540 population.(11)

Ratios which demonstrate the relationship between health manpower and population are meaningless unless discussed in relation to health care delivery systems and community needs. In most countries medical care is provided on a relatively sophisticated level to a small per-

centage of the population. Even the best of these ratios may be misleading for a number of reasons. First, in many of the developing countries, for example, doctors are concentrated largely in the urban centres, whereas upwards of 80 per cent of the population is spread through the rural areas. The doctor/per capita ratio often becomes as disproportionate as 1:100,000 in rural zones while they may be as favourable as 1:1,000 in urban areas.

Second, not all medical practitioners are engaged in providing primary health care services. Even if they were, the demand for health care services is often too great for medical practitioners to cope with all the needs of the people. The choice at present seems to be between relatively sophisticated care or no care at all. There is a need to alter the doctor-oriented health care delivery system. As Dr Halfdan Mahler, Director General of the World Health Organization, has said,

> it is nonsensical to insist upon using only doctors or other categories of professionally qualified personnel, if you can standardize or simplify your technology to make it safe and applicable through trained midwives or even people working part-time in health and part-time in other kinds of jobs.(12)

One of the more promising alternatives then is to begin to train and empower a variety of different types of paramedical personnel to provide some of the services now provided by doctors. The aim, however, is not to encroach upon the medical profession; rather it is to develop a rational and efficient way of furnishing basic health care to as many people as possible.

3. Paramedical personnel are available in sufficient numbers in many countries, and can be used to increase the coverage of basic health services.

Once it is recognized that, statistically, it is impossible for the number of doctors in practice at present to meet the basic health needs of a population the question that naturally arises is: who is best suited to assume some of these duties? The answer that immediately suggests itself is to look to the various cadres of paramedical personnel. These can be trained to provide specific and carefully defined services within the health delivery scheme. There really is nothing new in this. Paramedics have been used for centuries to provide a variety of health care services. Even so the idea has really not been exploited fully. The solution is, of course, "a child of necessity".

Examples abound which indicate the statistical sense of using non-doctors. For example the ratios of nurses and midwives per population in selected Commonwealth countries is as follows. In Ghana there is a nurse or midwife for every 1,200 population, in Kenya the ratio is one for every 2,470, in Jamaica one for each 490, Malaysia one per 1,050 and one for 630 in Fiji.(13)

The feldshers of Russia, the "barefoot" doctors of China and the medical assistants of Africa are all examples of how paramedicals can be used to augment the health care delivery systems. Of course, it is recognized that in some countries doctors outnumber some paramedical

cadres (in India there are two doctors for every nurse).(14) This does not preclude the possibility of utilizing nurses for primary health care. In any event there are others who can also be trained and utilized as new cadres are created.(15)

4. Paramedical personnel can be trained to perform safely functions normally done by a doctor and to provide other related follow-up services.

It would be a mistake to think that the case for use of health and auxiliary personnel rests on statistics alone. 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.

In this context we begin with the observation that many of the primary health care duties encompassed by this discussion involve the use of relatively simple, repetitive techniques and skills and that paramedical personnel can be suitably trained to assume these duties.

A substantial body of practice and literature lends support to these statements. In recent years non-doctors have been trained to perform safely a host of functions involving examination, diagnosis, treatment, prescription and surgery, all of which are usually reserved by law to doctors. They have also been taught to identify abnormal cases which require referral to a doctor, and to provide effective follow-up control services. The comparative results of these pilot projects indicate that the performance of these personnel is similar to that of doctors in terms of safety and efficiency.(17)

5. The cost-benefit, cost-effectiveness arising from the use of paramedical personnel is generally favourable.

It makes economic and practical sense to train paramedical personnel to do some of the traditional doctor tasks related to primary health care for at least four reasons.

First, because of the rather urgent need for the expansion of health care services in most countries what is required is a strategy that can produce trained workers as soon as possible. To wait until sufficient numbers of doctors are available would be foolhardy for several reasons, not the least of which is the length of time it takes to train them and the prohibitive costs. Indeed, the evidence is that there will never be enough doctors.

Second, in any event, it is a waste of scarce resources to have doctors doing many of the primary health care tasks. It is more efficient to use non-doctors and where applicable rationally divide the workload between doctors and the more numerous paramedicals. Doctors should only be required to handle the special referral cases requiring their expert attention. Doctors in a sense are a luxury in primary health care.

Third, paramedical personnel can be trained to provide primary health care in less time and in greater numbers, and can be maintained in the field at a lower cost, with little if any lost in the way of safety and efficiency. The same is essentially true where already-qualified paramedical personnel are active in the field. It is merely a question of giving them additional training and authorizing them to perform specific tasks.

Fourth, perhaps too much is made of saving doctor time. By utilizing paramedicals services are often brought closer to the recipients of primary health care. It is of little advantage for people to have to make long journeys to get to a clinic where a doctor is present to receive treatment which could be given otherwise. Costs in time and money for the people can be lessened if service delivery is achieved through paramedicals within the community.

6. Because of their proximity to the consumers, paramedical personnel can be effective conveyors of health care.

One of the factors which determines the success of any health programme is whether the consumers accept it. This often hinges on whether they have confidence in the personnel who offer the services. Where consumers receive treatment from individuals who are known to them, individuals who can take the time to allay their anxieties rather than treat them summarily, the reliance on these individuals for health care services tends to increase. This is no less true in the area of primary health care. The advantage is that paramedicals will often be closer to the people in socio-economic terms and in many instances may be selected from among the groups they serve.

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 proferring 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, inexpert 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 examplary 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"

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* 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.

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* 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.

IV. Sanctions Against Unauthorized or Negligent Medical and Health Care Practice

The sanctions* which may be applied against persons who engage in the unauthorized practice of medicine are a key concern of paramedicals undertaking expanded health care service roles. If they exceed the scope of their traditional practice, they place themselves in jeopardy, not only of disciplinary action from their own professions, but also of civil and criminal liability under the medical practice statutes. These would ostensibly apply where a nurse, a midwife or another non-doctor participated in health care activities without proper authorization.

A. Sanctions from Medical Profession

The primary source of sanctions against unauthorized practice are, quite naturally, the medical practice statutes. While it is possible for an individual to be punished for "falsely pretending to be registered" (Bangladesh) as a medical practitioner or to use any "name, title, addition" (Sri Lanka) which implies that he is permitted to practice medicine, the focus here is on sanctions against actual practice by unregistered persons, sanctions against doing something only a doctor is legally authorized to do. Section 38(b) of the Sri Lanka law is typical of the statutory prohibitions. It forbids anyone not registered under the act to "practice for gain, or profess to practice, or publish his name as practising medicine or surgery". The language of the Kenya statute is a carbon copy. There, anyone who is caught in violation is subject to a fine of up to 10,000 shillings or, if there is a default in payment, up to 12 months in prison.(55)

In Saskatchewan it is an offence for a person who is not "authorized under permit or other arrangement" to "furnish any medicine, treat any disease or ailment by medicine, drugs or other form of treatment, influence or appliance". (56) But not all activities of that nature are forbidden. The legislation focuses only on "practice' which is done "for hire, gain or hope of reward". Gratuitously provided advice, medicine and treatment is not subject to the graduated penalties specified in that section.

The Jamaican statute is even more thorough-going in that it forbids anyone who is not registered under the act to: a) practice medicine in any of its branches; b) diagnose or offer to diagnose or attempt to diagnose any human disease, ailment, deformity, defect, or injury or advise upon any physical or mental condition of any person; c) to prescribe or administer any drug, serum or any other substance or remedy, apply any apparatus, or perform any operation or manipulation, for the cure, treatment, or prevention of any human disease, ailment, deformity, defect or injury; or to act as an assistant or associate of any person who performs any of the above mentioned acts.(57)

As noted earlier, the decision as to whether an individual has infringed the rules on the practice of medicine has been left largely to the courts. In some instances such infringements carry with them

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* To avoid ambiguity here the word "sanction" is used throughout to connote a "penalty imposed for law-breaking."

criminal penalties. One interesting and pertinent example will suffice. In the case of State v Kwaku Nkyi, /1962/I Ghana Law Reports 197, the High Court at Kumasi in Ghana heard a complaint against a student nurse who had mistakenly injected a child with arsenic. (See Annex F). The child subsequently died. Left with the choice between convicting the nurse for manslaughter based on criminal negligence or for unauthorized medical practice, the Court took the view that he had violated the Medical and Dental Act, 1959. In short, he had practised medicine without authorization to do so. Though the nurse was trained to give injections, he had crossed the line which separates the practice of medicine from nursing and other health care professions. He had attempted, without other authorization, to use his skills, and apparently they were few, to make a diagnosis, prescribe a cure and treat the stricken child. Under normal circumstances the mere doing of the act, in this case the technical function of administering the injection, would not have been punishable. It was the fact that he made a diagnosis and proferred treatment that engaged the law. Kwaku Nkyi may seem a curious case. As Apaloo, J. said, 'that the accused was negligent is plain enough'. But that negligence was not "gross" enough to cross over the line into criminality. The case nevertheless points to one of the problems paramedicals face and hints at another, that of negligence, which will be discussed at greater length below.

B. Sanctions from Paramedical Professions

Whenever non-doctors provide medical care without proper authorization, particularly if they are nurses, midwives or other registered health care professionals, they also take the risk of being sanctioned by their own governing boards. The so-called "allied health professions" are particularly vigilant in curbing practices of their members which cross-over the somewhat ill-defined line into medical practice. For example, it is often said that nursing is a "caring" profession not a "curing" profession, that nurses may only assess the situation and "initiate" treatment, they may not "diagnose". In a way such distinctions may be nonsensically semantic. To borrow from an opinion from a U.S. court, the nurse

> has been trained, but to a lesser degree than a physician, in the recognition of diseases and injuries. She should be able to diagnose. . .sufficiently to know whether it. . . bears danger signs that should warn her to send the patient to a physician.(58)

Perhaps the word "diagnose" is used a bit loosely in the judgement but such a statement infers, as sometimes is the case, that the border lines between paramedical practice and medical practice are somewhat less than certain. Certainly some paramedicals learn from experience to make diagnoses. Nevertheless the law maintains that there is a distinct difference.

To a large degree the key to use of paramedicals is authorization. The issue is one of legal authority. In Barbados, for example, the Nurses and Midwives Rules, 1973, prohibit "the performance of any professional procedures not authorized by the Act or rules".(59) There are many functions they may perform so long as they have proper instructions or orders to do so from a 'medical practitioner'. All paramedicals are taught not to initiate treatment, save in emergencies,

unless there is an order from a doctor to do so. They are warned that they must be 'covered' by authorization. Sometimes this means that they will not proceed unless the order is in writing. A telephone communication or spoken order will not suffice. It is when paramedicals act without authorization that the threat of sanctions looms large. Typical of the professional sanctions paramedicals must be wary of are those found in the Nurses and Midwives Act, 1971 (Bahamas). The Nursing Council there has the power to suspend or strike off the register the name of any registered person who is guilty of

1. Dishonesty, negligence or incompetence in the peformance of his duties as a nurse, midwife or clinical nurse, as the case may be; or

2. Conduct that is unbecoming to a nurse, midwife or clinical nurse.(60)

The language of the Kenya statute is quite similar. There the person's name may be removed from the register if it is shown that he

b) has been guilty of negligence or malpractice in respect of his calling; or

c) has been guilty of impropriety or misconduct whether in respect of his calling or not.(61)

Quite rightly, these potential sanctions may, and sometimes do, make paramedicals reluctant to perform duties which are beyond their ken. But more often the reverse is true. Out of necessity many paramedicals indulge in forms of practice which are sanctionable. The paramedical professions have been quite vigilant, however, in sanctioning instances where non-doctors attempt to "wear the white coat". There are ways to avoid the apparent threat of the sanctions discussed here. These will be more fully discussed below. However, these sanctions are the sort which are on the minds of non-doctors each time it is suggested that they perform a task for which there is no clear authorization.

C. Exemptions from Sanctions

A number of jurisdictions within the Commonwealth have wrestled with the problem of providing wider health care services in the face of a shortage of doctors. Because of this, special provisions are in evidence within medical practice statutes which provide special exemptions to those who are not fully "qualified medical practitioners" but who may yet be authorized to carry on some form of medical practice however limited.

In Kenya anyone in the unauthorized practice of medicine is subject to a fine of 10,000 shillings and up to 12 months in prison.(62) But Section 13 of the Kenya statute makes exceptions. It empowers the Medical Board, where it is in the public interest to do so, to grant a licence under the signature of the Director of Medical Services to "any person who is not otherwise eligible to be registered as a medical practitioner". This licence gives the holder the "right to render medical services". Suitable limiting conditions may be placed on the various types of services to be provided under the licence, thus it serves to authorize a form of "limited" medical practice. These licencees are not considered registered medical practitioners. The

distinction made is between the right to "practice medicine" and the right to "render medical services". Registration under the Act or the granting of a special licence under Section 13 only permit those involved to work in the employ of government health schemes.(63) To practise privately another type of licence must be acquired.(64) Special exceptions are made, also, for any person in the employ of the Medical Department of the government or any approved health care institution who is called upon to render medical aid in the course of his duties.(65) This permits the widespread use of para-medicals in the government service and elsewhere without the fear of sanctions, particularly where regulations or standing orders permit expanded roles for these personnel. (See Annex G).

The statute in Sri Lanka, though perhaps sadly out of date, makes provision for allowing special categories of individuals to registered to practice medicine and surgery. Apothecaries* "actually employed in the public service" who are at present "in charge of a hospital or dispensary" or retired apothecaries who have worked for twenty years and been in charge of a hospital or dispensary for at least ten of those years, and estate apothecaries or estate dispensers, with special approval of the Director of Health Services, may register as medical practitioners.(66) In the case of estate apothecaries or dispensers, their practice is limited to the estates or groups of estates to which they are assigned. This may not be all that helpful in alleviating immediate manpower shortages as the number of years of experience required before registration for some of the personnel is quite substantial, but it serves as an example of the use of special registration requirements. Moreover, nothing in the statute interferes with medical practice undertaken by a verderala "according to the indigenous or ayurvedic systems". Special permits may also be issued in Saskatchewan to any person:

> who does not possess all the qualifications required by this Act to entitle him to be admitted to the practice of medicine in Saskatchewan, to practice medicine in any or all of its branches in any particular locality in the province where in the opinion of the council in view of the scarcity of duly qualified medical practitioners such person should be authorized to practice.(67)

In Malaysia it is an offence to practice medicine or surgery unless the person is "registered or exempted" (emphasis added).(68)

Some exemptions from the threat of sanction for practicing medicine may be found in other statutory texts. In Ghana, for instance, pharmacists are granted the authority to give medical advice including "treatment in the case of ailments of common occurrence where it is not reasonably practicable for the patient to consult" a doctor, or dentist for that matter. (68a) This is notwithstanding the provisions of Sections 23 and 24 of the Medical Practitioners and Dentists Act, 1959 which protects the right to practice medicine.

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* Names for cadres are an important issue. In the search for an adequate term to describe a non-doctor practitioner this has much to recommend it. It is non-pejoritive and could be used instead of "medical assistant". Apothecaries have a long history of practice in the Commonwealth as compounders and dispensers of medicines and as diagnosticians. Notice how the tradition is kept alive in the Ghana statute referred to below.

The use of special licences or exemptions is one technique which can be used to alleviate the fear on the part of paramedicals that they will be penalized for performing primary health care duties normally reserved to doctors, while at the same time achieving some flexibility in what types of personnel do what procedures.

D. Negligence

A brief word on the question of liability for negligence is appropriate. Suggestions that non-doctors assume traditional doctor roles raise the issue of consumer protection, alluded to above. Where paramedicals, whether authorized or not, provide primary health care services which result in injury to recipients, rules of negligence will apply to determine liability. However, at the present time the legal concern for malpractice and consumer protection, as evidenced by the number of law suits, seems to be a preoccupation of only the more developed countries. That does not mean that those interests should be ignored elsewhere. However, claims for malpractice based on negligence particularly in the sphere of primary health care, are virtually non-existent in the developing world.(69).

The mere fact that paramedicals are duly authorized to provide health care services does not mean that they can do so with impunity; neither does the fact that the person receiving the treatment has consented. Any attempt to provide health care carries with it the obligation not to do so negligently, that is, in a way which injures the recipient.

If it is that paramedicals are to assume doctor-functions two important questions arise. First, by what standards will the actions of non-doctors be measured? And, second, where paramedicals are negligent who ultimately will shoulder the burden of liability?

1. Standards of care applicable to paramedicals

We must necessarily begin with the notion that non-doctors who are performing acts which, if done negligently, are likely to cause physical damage are under a duty to exercise reasonable care and demonstrate the professional skills of a reasonably competent non-doctor.(70) Where they fail to exercise the degree of care and skill expected of the average paramedical, negligence may follow. This would seem to answer the question in a general way, bearing in mind that what we are talking about are non-doctor acts. The standards would rise as the levels of skills of the profession increase. What then of those non-doctors who have received a higher level of training? Should they be measured by the standards applicable to doctors? What even of those who are not authorized who are providing doctor-like care?

The case of R v Bateman, /1925/ 94 L.J.K.B. 791, seems to suggest at least some of the answers.

> If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking treatment. If he accepts the responsibility and

> undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering treatment.
>
> . . . The law requires a fair and reasonable standard of care and competence. This standard must be reached in all matters above mentioned.
>
> . . . As regards cases where incompetence is alleged, it is only necessary to say that the unqualified practitioner cannot claim to be measured by any lower standard than that which is applied to a qualified man.(71) (emphasis added).

Of course, where paramedicals are authorized to provide primary health care they would not really be classified as "unqualified practitioners" for most purposes. In that instance one of the few questions left would be what happens when they attempt a treatment which is beyond their power or competence. We have seen what the court in State v Kwaku Nkyi had to say -- it was unauthorized practice of medicine. What, for example, becomes of a paramedical who performs surgery? Bateman speaks of the standards which apply. Certainly, such a persons exposes himself to the risk of civil liability, if he causes injury. He "must answer the consequences if he fails to exercise the skill of a surgeon".(72) But here we must note that there may be negligence but no injury. Equally, there may be injury but no negligence. Circumstances dictate what result follows. The paramedical, for example, who undertakes surgery as an emergency measure may escape liability. Under normal circumstances, he will not be liable if it can be shown that his actions approximated "general and approved practice".(73) Yet the words used in Bateman still haunt us. Of cases involving treatment provided by unqualified practitioners it was said:

> . . . juries are not likely to hesitate in finding liability on the ground the defendant undertook, and continued to treat, a case involving the gravest risk to his patient, when he knew he was not competent to deal with it....

More will be said later about the necessity of teaching paramedicals the limits of their craft.

2. Who shoulders liability?

It is one thing to find negligence, quite another to determine who is liable in actuality for injuries which result from that negligence. Irrespective of who acted negligently, the question often arises: who is financially responsible? The answer is particularly pertinent to public programmes which undertake to use large numbers of paramedicals for the delivery of primary health care. If a paramedical gives the wrong injection and it results in injury, permanent or otherwise, who pays the claim? The paramedical or the employing agency?

With respect to the liabilities of the employing agency -- and in most cases it would be the Ministry of Health or a local

authority -- we can look to the series of cases decided in England some time ago. These provide, if only by analogy, some substantial hints as to who would be legally responsible for the negligence of non-doctors in the provision of health care. All deal with the liabilities of hospitals.

Time was when hospitals were not held vicariously responsible for the negligent acts of some types of people who worked in them.(74) This has changed. In Cassidy v Ministry of Health, /1951/ All E.R. 574; /1951/ 2 K.B. 343, the question of hospital liability for acts of employees came before the Court of Appeal. There an assistant medical officer was accused of negligence in the course of post-operative treatment -- bandages on the injured hand were left on too long and were too tight. It is the opinion of Denning, L.J. which is of interest.

In Cassidy Denning, L.J. elaborated on the principles set out by Lord Green, M.R. in Gold v Essex County Council, /1942/ All E.R. 237; /1942/ 2 K.B. 293. Denning, L.J. said among other things:

> In my opinion authorities who run a hospital, be they local authorities, government boards or any other corporation, are in law under the self-same duty as the humblest doctor; whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment.

He went on to say, this they must do "by the staff they employ. And if their staffs are negligent in giving the treatment they are just as liable for that negligence as is anyone who employs others to do his duties for him". Then he concluded:

> . . . when hospital authorities undertake to treat a patient, and themselves select and appoint and employ the professional men who are to give treatment, they are responsible for the negligence of those persons in failing to give proper treatment, no matter whether they are doctors, nurses or anyone else.

Denning appears to have opted for a rule which imposes a duty of care in all cases where care and treatment is offered by a staff selected, employed and paid by the hospital. Lord Green, M.R. in Roe v Minister of Health, /1954/ 2 K.B. 66, took the view that the hospital's obligations can be decided only after analysing the circumstance of each particular case. One author has ventured the opinion that the approach used by Green "is likely to be considered the correct one", though he also says that they both may lead to the same results.(75)

It is interesting to note that Gold, from which Denning took his lead, involved a hospital run under the powers granted in the Public Health Act, 1936, and therefore by analogy may have an influence in Commonwealth countries where health services are provided under the auspices of that type of legislation. Another case, Razzell v Snowball, /1954/ 3 All E.R. 429, was decided by reference to the National Health Service Act, 1946. There Denning, L.J. spoke of the relationship between the Minister and employed staff and hence of the seat of liability.

The Minister, he said,

> does not discharge his duty /under the Act/ merely by appointing competent doctors and nurses and competent specialists. He has not merely to provide staff. He has to provide their services; and inasmuch as their services consist of treating the sick it is his duty to treat the sick by means of their services.

In summary, because Ministries of Health have 1) the power to select paramedicals, 2) the authority to pay them, 3) the right to control their work methods and 4) the right to suspend or dismiss them, Ministries who undertake to provide health care to the community will be, in all likelihood, liable for the negligent acts of paramedicals they employ. The ultimate determination may well turn on the circumstances of each case, however, a distinction being made between injuries caused as a result of negligence for acts which are authorized and injuries caused by acts which exceeded the authority of paramedicals.

V. Primary Health Care, Paramedicals and the Law: A Brief Critique

In the realm of primary health care* the expressed needs are for diagnosis, treatment and midwifery. If primary health care is restricted to preventive medicine, however important it is, the community will not be satisfied. Their need is for relief of pain and treatment of illness. No community will come to someone for health care if all they offer is preventive care, however crucial that is for real improvement in the quality of life. For them preventive care alone is a non-solution. The real inducement of any respectable primary health care programme is that it offers curative medicine. Legislation and regulations must enable the paramedical cadres to do this.

A. Of the World and of the Law

The present state of the art is that most primary health care is, to put it in legal terms, de facto and not de jure. That is, paramedicals are providing primary health care (including diagnosis and treatment) as a matter of fact because the demand for the care is so great. At first glance there often is very little legal authorization for such practice. What care is extended is provided outside the law, sometimes on the fringes. For example, in Assam an illiterate refugee acts as a "nurse" to the individuals in a small refugee village. She diagnoses and treats. Frequently, her treatments take the form of drugs. She knows, for example, that the treatment for diarrhoea is one white tablet from the round green bottle taken four times a day. Her knowledge is no more sophisticated than that. As long as the drugs which come to her from the dispensary are consistently the same colour and shape and are placed in the same coloured or shaped bottles, she can function reasonably well. Legality matters little to her or to her patients; what they want is the care.

On the other hand, the law is often relevant to those who work within the legal limits of their jobs. Just as often it inhibits their ability to deliver appropriate and timely health care. The following example underscores the types of problems which need to be overcome.

> Mrs Suchin is now in labour and planning to deliver her seventh child at home, as she has done in the past. Of her six previous children four are still living, two having died in infancy from strange illnesses for which she did not know how to provide care. She is 34 years of age, has lived in the same village in Southeast Asia all of her life. As with her previous pregnancies, her elderly aunt will deliver the baby, although she did go to the government midwife for a checkup two months ago. The labour and delivery are easy, Mrs Suchin being a

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* We are constrained to remind the readers that what we are focusing on is a narrower reading of primary health care which includes just medical care

> good patient in labour. The baby is delivered and is apparently a healthy male infant. The placenta, however, does not come easily and the aunt becomes concerned. Mrs Suchin begins to bleed heavily; the government midwife is called. When she arrives, 45 minutes later, Mrs Suchin is pale and still bleeding. The midwife attempts to massage the uterus, but she has no appropriate medications with her because she is not allowed to give medications by injection . She then attempts to remove the placenta manually, but it tears and only part of it is removed. Mrs Suchin continues to bleed heavily and an attempt is made to move her the 40 miles to the nearest health centre with a physician. However, in transit, Mrs Suchin does from blood loss. An injection of Pitocin or ergotrate might well have saved her life. But in Mrs Suchin's country only doctors are supposed to give such medications.(76) (emphasis added).

As Rosenfield has said, "The problems relating to the delivery of health care were markedly exacerbated when the Western delivery system was adopted directly into predominantly rural societies where there were very few physicians".(77) To this Jelliffe has added:

> The health services of the Third World countries have tended to be ill-adapted imports from Europe and North America, with emphasis placed on costly curative institutionalized medicine, largely in urban centres and hospitals, manned by highly (and expensively) trained credential-oriented cadres of orthodox health staff, particularly physicians, attempting similar functions and duties of colleagues in developed countries.(78)

B. Where Primary Health Care and the Law Cross

Along similar lines one of the frequent criticisms of health care legislation is that it is not only sadly out of date, but that it is largely premised on the existence of a health care system which can only be maintained in the richer nations. To a large degree these criticisms are justified. Many of the former colonies have looked to the UK for model legislation. In earlier years, UK health care legislation spread to the India Office and then to other colonies. If indeed these laws were inappropriate in their new settings, once independence was achieved few attempts were made to modify these laws. Whereas new cadres of health workers have had to be developed or the roles which existing cadres take have been greatly expanded, legislation has, in the main, not shifted to accommodate these. This has left many health workers without legislative protection, witness the unprotected medical assistants and rural medical aides of Tanzania. In other countries appropriate legislation has been developed. The medical assistant in particular has been given special protection in several Commonwealth jurisdictions, the most recent ones being Fiji (1978) and the Gilbert Islands (1978). Yet the same gnawing question remains: if it is true, as many assert, that the health care delivery models taken over from the Western world were completely out of context in relation to primary health care, what of the legislative systems which were transplanted to support those models? No one is advocating here that the whole system be overturned, though such a radical approach may have its advantages. What is needed is a concerted effort to re-shape laws and regulations in a way

which facilitates primary health care.

Three brief examples will suffice. At present medical as well as legal standards limit the provision of curative services, including the prescription of drugs and the undertaking of various technical procedures, such as surgery, to a doctor.

1. Prescription and Distribution of Drugs

As noted earlier, one of the statutorily protected functions of a medical practitioner is to "prescribe" medications for the treatment of diseases and disorders. This authority is buttressed by the regulations which arise out of Pharmacy and Poisons Acts.(78a) While it is entirely possible that paramedicals will only need to deal with non-prescription medicines in pursuit of their role in primary health care, this is unlikely to be the case. One of the things they will have to be authorized to do is to handle, prescribe and distribute prescription drugs. In combination then the types of laws mentioned effectively undercut the potential role of non-doctors.

To inject a note of realism here some generalizations are necessary. First, many of the drugs which would be of common usage in primary health care programmes are subject to prescription. Second, though this is so, drugs in many developing countries can be purchased without prescription. This is most often the case only in metropolitan areas where there are pharmacies. In rural areas drugs cannot be as readily obtained, and, where they are most often are acquired through the health services. The health service may adhere vigorously to the doctor's prescription requirement and effectively limit the supply. Where this is so some thought will have to be given to training and authorizing non-doctors to prescribe and administer prescription drugs. This has been done in many countries. By taking an example from the field of family planning some of the possibilities may be seen. In most countries oral contraceptives were subject, initially, to the doctor's prescription requirement. Several readjustments have been made in this position. Three new approaches have been taken.

1. No prescription required for oral contraceptives: Antigua, Bangladesh, Grenada, Hong Kong, Jamaica, Papua/New Guinea.

2. Prescription for oral contraceptives required but either from trained paramedicals, such as nurses and midwives, or from other government authorized personnel, such as special family planning fieldworkers: Malaysia and Sri Lanka.

3. Initial doctor's prescription or subsequent doctor-screening for oral contraceptives required but pills provided on a continuous basis by a non-doctor dispenser on request: Fiji, Barbados and India.(79)

It is recognized that the experience with the Pill may not be applicable to all other medicines. But it does highlight the possibilities. Sometimes these new arrangements can be made without having to change any other piece of legislation. In those instances the change is brought about either under

the Pharmacy and Poisons Act itself (shifting drugs to the non-prescription schedule or to one which may be handled by non-doctors) or within the context of the Public Health Act (the Ministry of Health exercises its powers to authorize paramedicals to handle certain drugs). On occasion, however, provisions must be made for this change in various statutes. The recent Medical Assistants Act in Fiji contains an exemption which could well be adapted for use in legislation pertaining to other paramedicals. Section 7 says

> Notwithstanding the provisions of the Pharmacy and Poisons Act, but subject to any limitations or restrictions which may be imposed by the Permanent Secretary, a medical assistant may issue prescriptions and dispense any medicine or drug.

Advances of this sort will undoubtedly mean that, as in Zambia, different phamacopeias will have to be developed according to the staffing of the health centres. For example, different types of drugs may be available where a doctor is available than where a nurse or auxiliary is the person in charge. But this may tend to perpetuate the status quo unless nurses and auxiliaries are given authority to handle an increased number of drugs essential for primary health care.

2. Injections, Immunizations and Vaccinations

Similar problems arise over questions of who should be able to inject, immunize and vaccinate. These are all essential elements of any primary health care programme. In many Commonwealth countries paramedicals already provide the bulk of these services, though they must usually do so on the instructions of a doctor. In the primary health care context it is reasonable to expect paramedicals to be the purveyors of these services. Perhaps the distinction between preventive and curative treatment is useful here. Certainly on the preventive side, immunizations and vaccinations are tasks which a paramedical can be trained to handle without the necessity of a doctor peering over his shoulder. These could be provided as a matter of course. On the curative side, to the extent that paramedicals are trained to make simple diagnoses, they would also be capable of prescribing and administering antibiotic injections, including penicillin. But in order to assume these functions special authorization may be needed.(79a).

3. Surgery

Surgery is another of the statutorily protected functions of a doctor. For this reason surgery would usually be considered beyond the scope of primary health care practice. At present, apart from cleaning wounds and minor suturing, paramedicals would not normally engage in surgery. They may obviously, however, assist a doctor in surgery. But experience has shown that they can be trained and utilized to do various surgical procedures, some of them thought to be quite major. In Bangladesh even illiterate village girls have been trained to do minilaparotomies (female sterilization) (80) and other paramedicals are currently utilized for performing menstrual regulation,(81) a procedure which is akin to early abortion. In Africa cataract extractions are done by

paramedicals. Elsewhere, some paramedicals do Caesarian sections. In order to do these sorts of procedures special legal protection will have to be extended to paramedicals.

We have seen that two somewhat contradictory themes run through any discussion of the law, paramedicals and primary health care. Many paramedicals are filling doctor-like roles in the primary health care. Many are restrained because of the technicalities of the law. On one hand, one may ask what the law has to do with the first theme. It seems largely irrelevant. On the other, the technical requirements often impede a greater utilization of paramedicals. But this is largely a problem for the high level policy makers. At the grass-roots level the paramedical may not be worried about the niceties of the law. There is a happy medium between the two which combines legal protection for the paramedical with the assurance that he is appropriately trained to render the services he does. The latter implies that laws and regulations serve a greater function than merely providing legal protection. They do. They facilitate training, supervision, enumeration of tasks which may be performed by paramedicals, not to mention how these work to the benefit of the recipients of care. Just exactly how this may be achieved is our next subject.

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 lee-way, 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.

Conclusion

In the way of conclusion, we offer the following as summarizing guideposts.

First, whether to expand the roles of paramedical personnel or not is not a legal decision. It is a political one, that is to say a matter of national health policy. To be sure any decision of this sort is not without its legal elements, but if the will to change the current system controlling health care delivery is lacking, laws and regulations will not be changed. Such decisions as these are made within the context of each nation's needs and priorities. There is no ideal model that will work in all situations to fulfil the health requirements of each country. There are in existence, however, many suitable approaches which may solve the problem of ill-suited health care systems. The expanded use of paramedical personnel is one of the solutions. And many countries are awakening to this fact.

Second, in view of the difficulty created by the terminology used to describe these workers, their vital role in providing medical care to the vast majority of the population, and the existing rigid barriers separating the doctor and the paramedical, it may be necessary to completely re-evaluate the medical care delivery system. The whole medical care delivery system should be reviewed and redefined so that we may evaluate precisely what is "doctor's work" and what is "non-doctor's" work. Thus, by detailed job description on which training will be founded, we will be able to deliver medical care not through a conglomerate of "second bests" but through the best man or woman available to provide the specific function required.

Third, the team approach to medical care must be developed with no team member being required to work in isolation. Two types of teams are required: the primary health care team and the referral health care team. The former in turn would consist of two types of teams depending on the state of development of the health services system. One would consist mainly of "auxiliaries" with a few "paramedicals" and a few physicians, whereas the other would consist largely of physicians and paramedicals with a very few auxiliaries.(89) The primary health team provides medical care on an out-patient basis -- both preventive and curative care -- and will be reinforced with the other necessary components of health care such as sociological care and, where necessary, educational and agricultural advice. In the developing world, this team will care for the great majority of the "sick" and will operate from rural and urban health centres, clinics, surgeries and hospital out-patient departments. The referral health care team will be principally concerned with patients admitted to hospitals but will also act as a back-up and consultation service to the primary health care team.

Fourth, one of the barriers to the expanded use of paramedicals comes from within the medical profession itself. As Dr Mahler has noted, one of the constraints on WHO's efforts in primary health care is the "vested interests of the medical profession which still hangs as a cloud over many of the things we do".(90) On the whole, doctors, as well as lawyers, are a somewhat conservative lot. Some of that conservatism is not without reason. But recent attempts to bridge the gap between the level of available medical

technology and the level of health care received by a majority of the people in the world has had a rather unsettling effect on the profession. As doctors are the ones who largely control the practice of medicine, it is relatively easy for them to influence policy makers on matters concerned with health care.(91) What is considered good medical practice by the profession as a whole may tend to support the creation of unrealistic and impractical standards for primary health care at the local levels. Standards for the level of health care need not be universal. Common sense dictates that they be adapted to the local setting, not based on the level of practice possible in the relative sophistication of the hospital. In order for paramedicals to fulfil their full potential, some of the attitudes of the medical profession will have to undergo a change. At the same time there is little need to alienate the profession.

Fifth, wider use of the paramedical is no self-effectuating panacea. It is one element of a larger scheme of solutions that fit under the heading of health care policy. To the extent that the goals of health care policy are furthered by authorizing paramedicals to take up a more active role, it makes sense to adopt a policy which allows them to do so. The arguments in favour of paramedical use appear to us to be both cogent and realistic. But in order to implement the policy, existing impediments must be removed. This is where law becomes an important factor. As we have seen, the legal constraints on expanded paramedical involvement in the area of primary health care are considerable. Before paramedicals can effectively be used, the legal uncertainties relating to the practice of medicine, in general, must be scrutinized and eliminated. This will mean that statutes and ministry regulations will have to be changed. Given the present state of affairs, this is where the law can make an important contribution.

Sixth, a growing number of international symposia and organizations, both public and private, and national governments have in the past five years been advocating that laws relating to primary health care be analyzed and brought into conformity with the human right to health. One of the more effective ways to make this human right meaningful in the real world is to reform the law concerning the roles of paramedicals in health care. It is one way of ensuring that primary health care programmes "run at least twice as fast".

Seventh, insofar as the laws affecting the roles of paramedicals in primary health care are concerned, the following measures should be taken:

1. Laws and regulations should be analyzed in each county's setting to determine how they affect the roles of paramedicals.

2. Where the law impinges on paramedical practices, and where it is desirable to expand the roles of paramedicals, the appropriate laws and regulations should be changed.

3. Where roles are expanded, laws and regulations need to provide clear legal authority to paramedicals.

4. Laws and regulations having to do with health care need also to fulfil one of their essential functions, that of ensuring that the recipients of care are protected. For this reason laws and regulations must provide for adequate training, supervision and referral services.

Footnotes

1. See Declaration of Alma Ata, ICPHC/ALA/CONF.DOC./1 Rev. 1, pp.18-20 (1978).

2. Fendall, The Medicine of Poverty or What are People For? paper presented at Fourth Commonwealth Medical Conference, p.11 (1974).

3. Paxman, Lee and Hopkins, Expanded Roles for Non-physicians in Fertility Regulation: Legal Perspectives, n.4, p.53. Law and Population Monograph Series No. 41 (1976).

4. The Concise Oxford Dictionary, p.43 (5th ed. 1975).

5. Ibid., p.879.

6. Chowdhury and Chowdhury, Medical highlights -- the role of midwives and paramedics in voluntary sterilization programs, in M Schima and I Lubell (eds), New Advances in Sterilization, p.205 (New York: Association for Voluntary Sterilization, 1976).

7. These were suggested by Miller, The training and supervision of non-physicians in the delivery of family planning services in J. M. Paxman (ed.) Policies and Programmes for Utilizing in Non-Physician Personnel in the Delivery of Family Planning Services, p. 23 (Kuala Lumpur: IGCC, 1979). Papers and proceedings of an IPPF/IGCC Workshop in Pattaya, Thailand, 13-15 December 1978.

8. Paramedical Professions Act, 1975-5 (Barbados), First Schedule. See also the Regulations issued under section 32 of the Medical Dental Practitioner's Act, 1970 (Swaziland) which speaks of 'paramedical practitioners' and covers such personnel as chiropodists, diagnostic radiographers, dietitians, food inspectors, health inspectors, masseurs, medical technologists, optometrists, orthopaedic mechanicians and surgical appliance makers. The word is given a similar meaning in Australia. State Grants (Paramedical Services) Act, 1969.

9. Fendall, note 2 above.

10. WHO, World Health Statistics, vol. III, pp. 54-57 (1977).

11. Ibid., p. 73.

12. Interview: Dr Haldan Mahler, People, vol. 1, no. 1, pp. 10-12 (1973).

13. WHO, note 10 above, pp. 72-74.

14. Fendall, Auxiliaries in Health Care, p. 91 (Baltimore: The Johns Hopkins Press, 1972).

15. See British Medical Association, Report of Panel on Primary Health Care Teams, pp. 23-31 (1974).

16. For evidence of this in the field of family planning see Paxman, Lee and Hopkins, note 3 above, pp. 9-11.

17. Ibid.

18. See discussion below, pp.14 and 17.

19. Ibid.

20. See discussion below, pp.14 and 17.

21. Section 11.

22. Section 2 (e).

23. Section 20.

24. Section 38.

25. Section 35.

26. Ibid.

27. Section 27.

28. Hendrick, Forms of limited practice under the medical practice act, University of Miami Law Review, vol. 26, p. 805 (1972).

29. Section 34. Similar exemptions apply to those who practise "natural therapeutics", though the range of the services they provide is usually carefuly prescribed. In Swaziland, for example, those types of practitioners (chiropractors, homeopaths, naturopaths and electropaths) cannot: a) perform any surgical operation or administer any injection to any person; b) practise midwifery; withdraw blood from any person; c) treat or offer to treat cancer or prescribe a remedy for cancer or claim that any article, apparatus or substance will or maybe of value for the alleviation of the effects of the curing or treatment of cancer; e) perform any internal examinations on any person; . . . . The Control of Natural Therapeutic Practitioners Regulations, 1978, Regulation 10(1).

30. Medical Practitioners and Dentists Act, 1977, Section 26.

31. Section 41(b). A similarly worded section appears in the Nurses and Midwives Decree, 1972.

32. Ayurvedic Act (No. 31) of 1961.

33. Ayurvedic Medical Council Notice of 5 October 1970.

34. Udupa, The ayurvedic system of medicine in India, in Health by the People, K. W. Newell ed. pp. 53, 59-63 (Geneva: WHO, 1975).

35. The Nurses Act, 1950 as revised 1969, section 3 (Malaysia).

36. Zambia Registered Nurses Rules, Rule 21.

37. Nurses Registration Ordinance (Hong Kong), as amended 1970, sections 8, 14.

38. Nurses Act 1977, section 17.

39. Indian Nursing Council Act, 1947 (Act No. 48) as amended 1957, section 15A.

40. Nurses and Midwives (Registration) Act, 1973-10, sections 5(1), 16 and 20(1).

41. The Nurses Act, 1973, section 36.

41A. Nurses Regulations, 1971, Regulation 12(2) Fourth Schedule.

42. Nurses Act, 1934, Section 33(d). A similar situation exists in Uttar Pradesh (India) where Rule 4 on nursing practice says "The duties of a health visitor shall be such as prescribed by the Public Health Department." The recently repealed section 4(1)(b) of the Midwives Act, 1951 gave the Midwifery Board in the UK the power to make rules "regulating supervising and restricting within due limits the practice of certified midwives".

43. Stein (compiler), Inventory of Nursing Rules and Regulations, pp. 8-10 (New Delhi: The Trained Nurses Association of India, 1970).

44. Rules for Midwives, Rule 14; Rules for Health Visitors, Rule 5.

45. Nurses Registration Amendment Regulations, 1971, section 35(3) (Serial No. 46 of 1971). Statutes on midwifery do protect the profession though. In New Zealand any person who is not "a registered midwife, a registered obstetric nurse or registered comprehensive nurse" who "carries out obstetric nursing in any case where a medical practitioner has undertaken responsibility for the care of the patient" is subject to prosecution. Nursing Act, 1977, section 54(1)(b). The Nurses, Midwives and Nursing Assistants Act, 1978 in St Vincent contains a rather extraordinary clause which forbids anyone not registered to "act as a midwife, or act in attendance on a woman giving birth, whether or not for fee or reward". The penalty imposed is a fine not to exceed 500 dollars. Section 15(1). There is, however, a defence available to those charged if it can be shown that "in all the circumstances it was not possible, or the defendant took all reasonable steps, to secure the services of a midwife".

46. Ibid., section 35(1).

47. Nurses Registration Act, 1968, section 24.

47a. This is the view expressed in the UK Notices Concerning a Midwife's Code of Practice, 1978. The Code takes the view that there is no need to detail the sorts of treatment which are outside the province of midwifery as with modern developments the list would have to be amended frequently. Notice No. 2

48. These drugs are listed in Schedule IV of the Medicines (Prescription Only) Order, 1977.

49. Midwives Regulations, section 81.

50. The Nurses' Registration Amendment Regulations 1971, section 38(3). In New Zealand any person who must carry out "obstetric nursing" in an emergency is not subject to the sanctions imposed under the statute. Nurses Act, 1977, section 54(2)(a).

51. de Lourdes Verderese, Traditional Birth Attendant in Maternal and Child Health and Family Planning, WHO Doc. No. HMD/NUR/74.1 (1974). In St. Vincent midwives over the age of 30 who, though unregistered, have been practising for at least 10 years prior to 1978 are exempted from the sanctions imposed under the law. Nurses, Midwives and Nursing Assistants Act, 1978 section 15(3).

52. Section 16(5).

53. The Nurses and Midwives Rules, section 26(2).

54. Sections 6 and 12.

55. Sections 3 and 5.

55a. Medical Practitioners and Dentists Act, section 22.

56. Medical Profession Act, section 65.

57. Medical Act, 1972, section 13.

58. Cooper v National Motor Bearing Co., 146 Cal. App. 2d 229, 238 (1955).

59. Section 28(1).

60. Section 11(1)(c).

61. Nurses, Midwives and Health Visitors Act, section 22.

62. Medical Practitioners and Dentists Act, 1977, section 22.

63. Ibid., section 14.

64. Ibid., section 15.

65. Section 22.

66. Medical Ordinance, section 41.

67. Medical Profession Act, section 68a.

68. Medical Act, 1971, section 33(e).

68a. Pharmacy and Drug Act, section 14(1).

69. Notes on fieldtrip to Malaysia, 11-17 July 1976.

70. Percy, Charlesworth on Negligence, paragraph 295. London: Sweet and Maxwell (5th ed.) 1971.

71. This was the view taken more than half a century before. See Rudlock v Lowe /1865/ 4 F & F 519.

72. James, General Principles of the Law of Torts, p.196 (London: Butterworths, 3d ed., 1969).

73. Marshall v Lindsey C.C. /1935/ 1 K.B. 516, 540 per Maughan, L.J.

74. See Hillyer v Governors of St Bartholomew's Hospital, /1909/ 2 K.B. 820. Hillyer is no longer good law.

75. Nathan and Barrowclough, Medical Negligence, pp. 132-33 (London: Butterworths, 1957).

76. Rosenfield, Modern medicine and the delivery of health services: lessons from the developing world, Man and medicine, vol. 2, no. 4, p. 279 (1977).

77. Ibid., p. 285.

78. Jelliffe and Jelliffe, Nutrition programmes for pre-school children, American Journal of Clinical Nutrition, vol. 25, p. 595, (1972).

78a. These in their turn prevent anyone other than a registered pharmacist, or someone under his direct supervision, from compounding, preparing, mixing or dispensing "any medicine on the prescription of a medical practitioner". The Pharmacy Act, 1948, as modified to 1975, section 42(1). Doctors, of course, may dispense to their own patients.

79. Paxman and Cook, Law and planned parenthood in Potts and Bhiwandiwala, eds., Birth Control -- An International Assessment (Lancaster: Medical Technology Press, 1979).

79a. The Medical and Dental Decree, 1972 in Ghana would permit paramedicals, if licensed by the Director-General of Health Services, to give "injections of drugs into the skin, subcutaneous tissues, muscles or veins of persons". Section 41(c). In Zambia the syllabus for nursing contains this note on immunizations and vaccination. The training is "restricted to the execution as directed, and specifically exclude(s) subsequent assessment." Zambia Registered Nurses (Training) Rules, 1968, Fourth Schedule.

80. Chowdhury and Chowdhury, note 6 above. See also Shattock and Fendall, The role of the paramedical in voluntary sterilization and menstrual regulation, in The Symposium on Law and Population, pp. 140-168 (New York: UNFPA, 1974).

81. Lady health visitors are utilized as MR service providers after two weeks' training. See Summary of Group Discussion in Paxman, note 7 above.

82. Where doctors have over a period of time often delegated tasks to certain paramedicals the delegation becomes accepted as acceptable medical practice.

83. Health-care lessons from international experience, New England Journal of Medicine, vol. 290, p.1376 (1974).

84. Nurses, Midwives and Health Visitors (Midwives) Regulations, section 33.

85. Section 9(1B).

86. Personal communication with Dr. Fred T. Sai.

87. The Nurses (Amendment) Act, 1975).

88. This was the approach taken in the recently enacted Nurses, Midwives and Health Visitors Act, 1979, in order to manage the interests of groups like the midwives. Sections 3 and 4.

89. British Medical Association, Report of the Panel on Primary Health Care Teams (1974).

90. Note 12 above, p. 10.

91. Indeed, in some countries the Medical Council controls the paramedical cadres as it has the authority to make rules affecting nursing training and practice. See Medical and Allied Professions Act, 1965, sections 32 and 33.

ANNEX A

Kenya Gazette Supplement No. 74 (Acts No. 6)

THE REPUBLIC OF KENYA

KENYA GAZETTE SUPPLEMENT

ACTS, 1977

NAIROBI, 11th NOVEMBER, 1977

CONTENTS

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THE MEDICAL PRACTITIONERS AND DENTISTS ACT, 1977

No. 20 of 1977

Date of Assent: 8th November, 1977

Date of Commencement: By Notice

ARRANGEMENT OF SECTIONS

Section

An Act of Parliament to consolidate and amend the law to make provision for the registration of medical practitioners and dentists and for purposes connected therewith and incidental thereto

ENACTED by the Parliament of Kenya as follows:—

Short title and commencement.

1. This Act may be cited as the Medical Practitioners and Dentists Act, 1977, and shall come into operation on such day as the Minister may, by notice in the Gazette, appoint.

Interpretation.

2. In this Act, unless the context otherwise requires—

"Board" means the Medical Practitioners and Dentists Board constituted under section 4 of this Act;

"dental practitioner" and "dentist" means any person registered under this Act as a dentist;

"dentistry" and "dental services" include the performance of any such operation and the giving of any such treatment, advice or attendance as is usually performed or given by dentists, and any operation or any treatment, advice or attendance on or to any person preparatory to or for the purpose of or in connection with the fitting, insertion or fixing of artificial teeth;

"medical practitioner" means any person registered under this Act as a medical practitioner;

"private practice" means the practice of medicine or of dentistry, as the case may be, for a fee either in kind or cash;

"private practitioner" means a person registered under this Act as either a medical practitioner or a dentist who is also licensed under section 15 of this Act to practise medicine or dentistry for fees either in cash or in kind;

"register" means the register of medical practitioners and dentists which the Registrar is required by section 5 of this Act to keep;

"Registrar" means the Registrar of Medical Practitioners and Dentists constituted by section 5 of this Act.

Construction of terms in any written law.

3. The words "legally qualified medical practitioner", "duly qualified medical practitioner" or any words importing a person recognized by law as a medical practitioner or a member of the medical profession, when used in any written law with reference to such person, shall be construed to mean a person registered as a medical practitioner under this Act or, where the context so admits, a person who is licensed by the Board under section 13 of this Act.

The Medical Practitioners and Dentists Board.

4. (1) For the purposes of this Act, there shall be constituted a Board to be known as the Medical Practitioners and Dentists Board, which will consist of the following members, all of whom shall be either medical or dental practitioners of good character and good standing—

(*a*) the Chairman, to be appointed by the Minister;

(*b*) the Director of Medical Services or the person for the time being acting in that post;

(*c*) a Deputy Director of Medical Services, to be nominated by the Minister;

(*d*) four medical practitioners to be nominated by the Minister;

(*e*) a representative of the Faculty of Medicine of the University of Nairobi who shall be nominated by the Faculty Board; and

(*f*) five medical practitioners and two dentists, who shall be elected by the votes respectively of all medical practitioners and of all dentists at the prescribed times and in the prescribed manner:

Provided that notwithstanding the provisions of this subsection, the Minister may, if at any time it appears to him that the Board has failed to carry out any of its functions under this Act in the national interest, revoke or annul the appointment, nomination or election of any member of the Board and may himself nominate a new member in the place of such member for the remainder of the period of office of such member under subsection (3) of this section.

(2) The Board shall elect a Deputy Chairman from amongst its members.

(3) The members referred to in paragraphs (*a*), (*c*), (*d*), (*e*) and (*f*) of subsection (1) of this section shall hold office for a period of three years from the date of their appointment, nomination or election, as the case may be, but shall be eligible for re-appointment, re-nomination or re-election.

(4) The Chairman or, in his absence, the Deputy Chairman shall preside at all meetings of the Board and, in the absence for any reason of both the Chairman and the Deputy Chairman, the other members of the Board who are present at any meeting shall choose one of the members to act as chairman at that meeting.

(5) Each member of the Board shall have a deliberative vote and the Chairman for the time being at any meeting of the Board shall, in addition to his deliberative vote as a member of the Board, have a casting vote.

(6) If any member of the Board, other than the Chairman, the Director of Medical Services or the Deputy Director of Medical Services nominated under paragraph (*c*) of subsection (1) of this section, is temporarily incapacitated by illness or is otherwise prevented from performing his duties as a member thereof, the Board may appoint a medical or dental practitioner to act in the place of such member during his incapacity or absence.

(7) When any member, who has been appointed, nominated or elected under paragraph (*a*), (*c*), (*d*), (*e*) or (*f*) of subsection (1) of this section, dies or resigns from the Board, or is otherwise permanently unable to attend meetings of the Board, the Minister may, after consulting the Board, appoint a medical or a dental practitioner to act as a member of the Board until such time as a permanent member is appointed, nominated or elected to fill the vacancy.

(8) Seven members of the Board (including the chairman of the meeting) shall constitute a quorum at any meeting of the Board, and all acts, matters or things authorized or required to be done by the Board may be decided at any meeting at which a quorum is present.

(9) The powers of the Board shall not be affected by any vacancy in the membership thereof.

(10) The Board shall meet at least once in every three months.

(11) The Chairman or, in his absence, the Deputy Chairman, shall convene a meeting of the Board on receiving written requests by at least five of its members.

(12) A member of the Board who absents himself from two consecutive meetings without prior permission from the Chairman or, in his absence, from the Deputy Chairman, shall automatically lose his place on the Board and the vacancy so created may be filled temporarily in accordance with subsection (7) of this section.

(13) The Chairman or, in his absence, the Deputy Chairman, may, with prior approval of the Board, appoint suitable persons, who may be persons employed in the public service, to assist in carrying out particular decisions of the Board or particular duties or investigations for the Board.

(14) Subject to the provisions of the Act and to any rule as to procedure made under section 23 of this Act, the Board shall have power to regulate its own procedures.

Registrar and register.

5. (1) For the purpose of this Act, there shall be a Registrar of Medical Practitioners and Dentists.

(2) The Director of Medical Services shall be the Registrar, and shall perform such duties in connection with the register as are prescribed by this Act.

(3) The Registrar shall keep a register of medical practitioners and dentists in the prescribed form.

Registration of medical practitioners and dentists.

6. (1) Every person eligible to be registered as a medical practitioner or as a dentist may apply in the prescribed form to the Registrar for registration in the register, and every such application shall be accompanied by the prescribed fee.

(2) Where any person has complied with the provisions of subsection (1) of this section and has been accepted by the Board as being eligible for registration and has satisfied the Registrar that he has been so accepted, he shall be registered.

Certificate of registration.

7. The Registrar shall issue to every person registered under this Act, a certificate in the prescribed form.

Correction of register.

8. (1) The Registrar shall from time to time make any necessary alterations and corrections in the register in relation to any entry therein.

(2) The Registrar shall remove from the register—

(*a*) the name of every deceased person;

(*b*) the name of every person convicted of an offence under section 19 of this Act;

(*c*) the name of every person whose name the Board has under section 20 of this Act directed should be struck off the register; and

(*d*) any entry which has been incorrectly or fraudulently made in the register.

(3) (*a*) The Registrar, with the consent of the person concerned, may remove from the register the name of a person who has ceased to practise.

(*b*) The Registrar shall, not later than 1st July in each year, send by registered post to every person registered in the register a notice inquiring whether or not such person has ceased to practise or has changed his address, and, if no answer is returned to the inquiry within six months from the posting thereof, the name of that person may be removed from the register.

(*c*) Any name removed under this subsection may, at the request of the person concerned and on payment of the prescribed fee, be reinstated by the Registrar.

(4) It shall be the duty of the Registrar-General of Births and Deaths to notify the Registrar of the death of any registered medical practitioner or dentist.

Publication of register.

9. (1) The Registrar shall publish in the Gazette as soon as may be practicable after registration the name of every medical practitioner or dentist registered in the register.

(2) The Registrar shall once in every year, as soon as convenient after 1st January, but not later than 31st March, publish in the Gazette, a list containing the names, qualifications and registered addresses of all registered medical and dental practitioners.

(3) It shall be the duty of every medical and dental practitioner to inform the Registrar immediately of any change in his registered address.

Publication *prima facie* evidence of registration.

10. (1) The publication of the list of registered medical and dental practitioners in the Gazette shall be *prima facie* evidence that the persons named therein are registered under

this Act, and the absence of the name of any person from such list shall be *prima facie* evidence that such person is not so registered.

(2) All register books and all copies thereof or extracts therefrom certified under the hand of the Registrar shall be receivable in evidence in all courts.

Persons eligible to be registered as medical or dental practitioners.

11. (1) Subject to the provisions of this section, a person shall be eligible for registration under this Act as a medical or dental practitioner if he is the holder of a degree, diploma or other qualification which is recognized by the Board as making him eligible for registration, and—

(*a*) after obtaining such degree, diploma or other qualification, he has engaged in training employment in a resident medical capacity in one or more institutions approved by the Board for such period, being not less than one year, as the Board may approve; and

(*b*) he satisfies the Board that, whilst engaged in training employment under paragraph (*a*) of this subsection, he has acquired sufficient knowledge of, and experience in, the practice of medicine or dentistry, as the case may be; and

(*c*) he satisfies the Board that he is a person of good moral character and a fit and proper person to be registered under this Act.

(2) In any case where the Board does not recognize a degree, diploma or other qualification in medicine or dentistry held by any person as making him eligible for registration, it shall take steps to assess his suitability for registration and for the purpose of so doing may require him to attend any interview and to undergo any oral or written examination.

(3) The Board may, after assessing the suitability for registration of a person under subsection (2) of this section, direct that before registration he shall undergo such further period of training or pass such further examination as it may specify.

(4) The Board shall not authorize the registration of any person until it is satisfied that the requirements of subsection (1) of this section have been fulfilled or, in the case of any person referred to in subsection (2) of this section, that the

requirement of paragraphs (*a*), (*b*) and (*c*) of subsection (1) have been fulfilled and that any further period of training or examination directed by it under subsection (3) has been completed or passed.

(5) The Board may, where it considers it expedient so to do, delegate the assessment of suitability for registration under subsection (2) of this section to a committee of the Board which shall, after making such assessment, make recommendations to the Board accordingly.

Person registered may have additional qualifications inserted in register.

12. Every person registered under this Act who has obtained any higher degree or qualification than the qualification in respect of which he has been registered shall be entitled to have such higher degree or additional qualification inserted in the register in substitution for or in addition to the qualification previously registered, on the payment of the prescribed fee.

Licensing of persons to render medical or dental services.

13. (1) Notwithstanding any of the other provisions of this Act, the Board may, if it is satisfied that it is in the public interest to do so, confer upon any person who is not otherwise eligible to be registered as a medical practitioner or as a dentist under the provisions of this Act, by the issue, under the signature of the Director of Medical Services, of a licence to do so, the right to render medical or dental services.

(2) Every such licence shall be for such period and may contain such conditions as the Director of Medical Services shall, with the consent or on the instruction of the Board, impose.

(3) Any licence issued under this section may be cancelled or revoked and withdrawn at any time by the Director of Medical Services with the consent or on the instructions of the Board.

Effects of registration and licence under section 13.

14. (1) Registration as a medical practitioner or a dentist under this Act, or the granting of a licence under section 13 of this Act, shall only entitle the person so registered or so licensed to practise medicine or dentistry or to render medical or dental services, as the case may be, in a salaried post under a Government or Local Government health scheme or in such salaried posts in such institutions as the Board may from time to time approve.

(2) No medical practitioner or dentist shall act as or engage in private practice as a private practitioner or may be employed by a private practitioner, unless he holds a licence to engage in private practice under the provisions of section 15 of this Act.

Licence for private practice.

15. (1) The Board may authorize the Registrar to issue to a medical practitioner or a dentist who has applied in the prescribed form and whom the Board considers has had suitable working experience in medicine or in dentistry, as the case may be, a licence to engage in private practice on his own behalf as a private practitioner or to be employed, either whole time or part time, by a private practitioner.

(2) The Registrar shall issue, on payment of the prescribed fee, a licence in the prescribed form to persons who are authorized by the Board under subsection (1) of this section.

(3) Such licences shall be granted for a period of one year at a time and shall state whether the person so licensed may practise as a private practitioner on his own behalf or may be employed by a private practitioner.

(4) The Board may refuse to issue or to renew a licence to engage in private practice to any person and may withdraw any such licence it has issued.

(5) No premises may be habitually used for the purposes of private practice unless they are authorized for such use by the Board.

(6) Any person aggrieved by any decision of the Board under this section may appeal to the High Court, and in any such appeal the High Court may annul or vary the decision as it thinks fit.

Licences to be published in Gazette.

16. The issue and the cancellation, revocation or withdrawal of any licence under section 13 or section 15 of this Act shall be published in the Gazette.

No fees recoverable unless person licensed under section 15.

17. No person shall be entitled to recover any charge for any medical or surgical advice or attendance, or for the performance of any operation as a medical practitioner or dentist, or for any medicine which he has prescribed and supplied as a medical practitioner or dentist, unless he is at the time appropriately licensed under section 15 of this Act.

Certificate not valid unless signatory registered, etc.

18. No certificate or other document required by law to be signed by a duly qualified medical or dental practitioner shall be valid unless signed by a person registered as a medical or dental practitioner under this Act or, where the context so admits, by a person who is licensed by the Board under section 13 of this Act.

Penalty for fraudulently procuring registration or licence.

19. Any person who wilfully procures or attempts to procure himself to be registered or licensed under any of the provisions of this Act by making or producing or causing to be made or produced any false or fraudulent representation or declaration either orally or in writing, and any person aiding or assisting him therein, shall be guilty of an offence and shall be liable on conviction to a fine not exceeding three thousand shillings or to imprisonment for a term not exceeding twelve months, or to both such fine and such imprisonment; and if any person convicted of an offence under this section is registered or licensed under this Act the Registrar shall forthwith remove the name of such person from the register or cancel his licence, as the case may be.

Disciplinary proceedings.

Cap. 63.

20. (1) If any medical practitioner or dentist registered or any person licensed under this Act is convicted of any offence under this Act or under the Penal Code, whether the offence was committed before or after the coming into operation of this Act, or is, after inquiry by the Board, found to have been guilty of any infamous or disgraceful conduct in a professional respect, either before or after the coming into operation of this Act, the Board may, subject to subsection (9) of this section, remove the name of such person from the register or cancel any licence granted to such person, as the case may be.

(2) Upon any inquiry held by the Board under subsection (1) of this section the person whose conduct is being inquired into shall be afforded an opportunity of being heard, either in person or by an advocate.

(3) For the purpose of proceedings at any inquiry held by the Board, the Board may administer oaths and may, subject to the provisions of any rules made under section 23 of this Act, enforce the attendance of persons as witnesses and the production of books and documents.

(4) Subject to the foregoing provisions of this section and to any rules as to procedure made under section 23 of

this Act, the Board shall have power to regulate its own procedure in any disciplinary proceedings.

(5) The power to direct the removal of the name of a person from the register or to cancel the licence of any person shall include a power exercisable in like manner to direct that during such period as may be specified in the order the registration of a person's name in the register or the licence granted to him shall not have effect.

(6) Any person aggrieved by any decision of the Board under the provisions of this section may appeal within thirty days to the High Court and in any such appeal the High Court may annul or vary the decision as it thinks fit.

(7) The provisions of this section, in so far as they relate to the cancellation or suspension of licences, shall be in addition to and not in derogation of the provisions of section 13 or 15 of this Act.

(8) Any person who fails when summoned by the Board to attend as a witness or to produce any books or documents which he is required to produce shall be guilty of an offence and liable to a fine of two thousand shillings or to imprisonment for one month.

(9) Notwithstanding the provisions of subsection (8) of section 4, the Board shall not remove the name of any person from the register, or cancel any licence granted to any person, under subsection (1) of this section unless at least ten members of the Board so decide.

Effect of removal, cancellation or suspension.

21. (1) Where the name of any person has been removed from the register, the name of that person shall not, subject to the provisions of this Act, be again entered in the register except by order of the Board.

(2) Where an order has been made for the removal of a person's name from the register, or for suspending the effect of a person's registration under this Act, or for cancelling or suspending a licence granted to a person under this Act, the Board may either on its own motion or on the application of the person concerned, and in either case after holding such inquiry as the Board thinks fit, cause the name of that person to be restored to the register or terminate the suspension of the registration, or, as the case may be, grant a new licence or terminate the suspension of the existing licence, in any such case either without fee or on the payment of such fee, not exceeding the appropriate registration or licence fee, as the Board may determine.

(3) Subsection (1) of this section shall not apply when a person's name has been removed from the register at his request or with his consent in circumstances under which it could not have been removed without consent, and the name of such person shall on his application and on the payment of the prescribed fee, if any, be restored to the register.

Penalty for unregistered and unlicensed person practising.

22. Any person who wilfully and falsely takes or uses any name, title or addition implying a qualification to practise medicine or surgery or dentistry, or, who, not being registered or licensed under this Act, practises or professes to practise or publishes his name as practising medicine or surgery or dentistry or who, not being licensed under section 15 of this Act, practises as a private practitioner, shall be guilty of an offence and liable to a fine not exceeding ten thousand shillings, or in default of payment to imprisonment for a term not exceeding twelve months:

Provided that nothing in this section contained shall make it an offence for any person in the service of—

(i) the Medical Department of the Government; or

(ii) any hospital, dispensary or similar institution which the Director of Medical Services, by notice in the Gazette, declares to be an approved institution for the purposes of this section,

to render medical assistance in the course of his duties in such service or for a person to carry out treatment under the direction, supervision and control of a medical practitioner or a dentist or of a person licensed under section 13.

Rules.

23. The Minister, after consultation with the Board, may make rules generally for the better carrying out of the provisions of this Act, and any such rules may, without prejudice to the generality of the foregoing power—

(*a*) prescribe anything required by this Act to be prescribed;

(*b*) provide for the procedure to be followed by the Board in any inquiry under section 20 of this Act;

(*c*) provide for enforcing the attendance of witnesses and the production of books and documents at any inquiry held by the Board;

(*d*) prescribe any forms to be used in connection with this Act or any fees to be charged under the provisions of this Act.

Attorney-General's consent.

24. A prosecution for an offence under this Act shall not be instituted in any court without the written consent of the Attorney-General.

Finance.

25. The Minister may, with the consent of the Treasury, out of money provided by Parliament—

(*a*) make to the Board such grants as may be necessary to enable it to discharge its functions under this Act;

(*b*) pay remuneration and travelling and other allowances to the members of the Board (other than members who are public officers in receipt of a salary);

(*c*) make such other payments as may be necessary to give effect to the provisions of this Act.

Repeal of Cap. 253 and savings.

26. (1) The Medical Practitioners and Dentists Act, hereinafter referred to as the repealed Act, is hereby repealed.

(2) Notwithstanding any of the other provisions of this Act, any person whose name is registered as a medical practitioner or as a dentist, as the case may be, under the provisions of the repealed Act immediately before the date of the coming into operation of this Act, and whose name was not then the subject of an order to be struck off or removed from the register under the repealed Act, shall be entitled to be registered, on the payment of the prescribed fee, as a medical practitioner or as a dentist, as the case may be, under this Act.

(3) Notwithstanding any of the other provisions of this Act, any person who, immediately before the coming into operation of this Act, is both registered as a medical practitioner or as a dentist, as the case may be, and is engaged whole time in private practice and whose name was not then the subject of an order to be struck off or removed from the register under the repealed Act, shall be entitled to a licence to engage in private practice under this Act.

(4) For the avoidance of doubt, it is hereby declared that once a person is registered, or a licence is granted to a person, in consequence of the provisions of subsection (2) or (3) of this section, all the provisions of this Act shall apply to such person as if he had been first registered or licensed under this Act.

ANNEX B

Supplement to Official Gazette dated 31st May, 1973.

NURSES AND MIDWIVES (REGISTRATION) ACT, 1973–10

Arrangement of Sections

Part I

PRELIMINARY

Section

Part II

NURSES

Part III

MIDWIVES

Part IV

NURSING ASSISTANTS

Part V

MISCELLANEOUS

BARBADOS

I assent
A. WINSTON SCOTT
Governor-General
3rd May, 1973.

1973 – 10

An Act to repeal the Midwives and Nurses Registration Act, 1932 and make new provision for the registration of nurses and midwives and for the enrolment of nursing assistants and for connected purposes.

(By Proclamation). Commencement.

ENACTED by the Parliament of Barbados as follows:-

Part I

Preliminary

Short title.

1. This Act may be cited as the Nurses and Midwives (Registration) Act, 1973.

Interpretation

2.(1) For the purposes of this Act –

"Council" means the General Nursing Council established by section 3;

"medical practitioner" has the same meaning as in section 2 of the Medical Registration Act, 1971;

1971-10.

"Minister" means the Minister responsible for health;

"midwife" means a person whose name appears on the Midwives' Register;

"nurse" means a person whose name appears on the Nurses' Register;

"nursing assistant" means a person whose name appears on the Nursing Assistants' Roll;

"Practising Certificate" means a certificate issued under section 10;

"register" means the appropriate register to be kept by the Registrar under section 5 or 16, as the case may be;

"roll" means the Nursing Assistants' Roll to be kept by the Registrar under section 19;

"Registrar" means the Registrar of the Supreme Court;

"Secretary" means the person for the time being performing the functions of Secretary to the Council.

(2) A reference in this Act to a female person includes a reference to a male person.

Establishment of Council.

3.(1) For the purposes of this Act there is hereby established a Council to be known as the General Nursing Council.

(2) The Council shall be a body corporate and section 21 of the Interpretation Act, 1966 applies thereto.

Schedule.

(3) The provisions of the Schedule shall have effect with respect to the constitution of the Council and otherwise in relation thereto.

Council to report to and advise Minister.

4. The Council shall –

(a) as soon as practicable after the beginning of each year submit to the Minister a report of its activities during the preceding year; and

(b) advise the Minister on matters relating to nursing care for the sick

and injured and midwifery services in Barbados, and in particular on the establishment of a suitable recruitment and training programme for the maintenance of such nursing care and midwifery services.

Part II

Nurses

Nurses' Register.

5.(1) The Registrar shall keep a register to be known as the Nurses' Register in which he shall cause to be entered the name of every person required by section 6 or entitled under section 7 to be registered as a nurse together with the following particulars in respect of each such person —

(a) her full name and address;

(b) the date of her registration;

(c) a description and the date of the qualification in respect of which she is registered.

(2) The Nurses' Register shall be divided or classified in a manner approved by the Council respecting nurses qualified to practise general nursing, psychiatric nursing or such other branch of nursing as the Council determines.

(3) The Nurses' Register shall at all reasonable times be open to inspection at the Registration Office.

(4) The Registrar shall make such alterations in the addresses and qualifications of nurses as are

necessary and shall remove from the Nurses' Register the name of any nurse who is deceased or no longer qualified to practise nursing in Barbados.

Registration of existing nurses.

6. The Registrar shall immediately upon the commencement of this Act cause to be entered in the Nurses' Register the particulars specified in paragraphs (a), (b) and (c) of section 5(1) of all persons who immediately before such commencement were registered under the Midwives and Nurses Registration Act, 1932 without application on the part of such persons and without the payment of any fee and pending such entry those persons shall be deemed to be nurses.

1932-1.

First Registration.

7.(1) Any person who after the commencement of this Act applies to the Council to be registered as a nurse who satisfies the Council –

(a) that she is qualified to be so registered; and

(b) that she is a fit and proper person to practise nursing in Barbados; and

(c) that she is of the prescribed age,

is entitled upon compliance with the requirements of this Act and on payment of the prescribed fee to be registered as a nurse.

(2) Subject to subsection (6) a person is qualified to be registered as a nurse who –

(a) has completed the prescribed course of training at a place of training in Barbados recognised by the Council and has passed the prescribed examinations; or

(b) holds a diploma, certificate or other status or form of recognition granted in a place outside Barbados by a duly constituted body empowered by the law of that place to confer authority to practise nursing and which is recognised by the Council as being equivalent to the qualification required by paragraph (a).

(3) The Council may, with the approval of the Minister recognise –

(a) any hospital, school or institution as a place of training for the purposes of paragraph (a) of subsection (2);

(b) any diploma, certificate or other status or form for the purposes of paragraph (b) of subsection (2).

(4) An application for registration shall be made in the form approved by the Council.

(5) An applicant for registration shall furnish to the Secretary –

(a) evidence of her qualifications;

(b) proof of her identity; and

(c) such further and other information as the Council requires in respect of the matters referred to in paragraphs (b) and (c) of subsection (1).

Power of Council to require examination.

(6) The Council may require an applicant for registration under paragraph (b) of subsection (2) to submit to examination in such subjects as it considers necessary to establish that she possesses satisfactory nursing training.

Exemptions.

8. Where the Council is satisfied that a person although not qualified to be registered under section 7(1) has completed such training, whether in Barbados or elsewhere, as in its opinion may be recognised as part of the qualification for registration under paragraph (a) of that section, the Council may, upon the application of that person, direct that she be exempted from any part of the prescribed course of training mentioned in that paragraph and that she be registered upon compliance with any conditions as to further training and the passing of examinations as the Council thinks fit and upon payment of the prescribed fee.

Certificate of Registration to be issued by Council.

9.(1) Where the Council is satisfied that a person is registered under section 7(1), the Council shall issue to that person a certificate of registration.

(2) Where the Council refuses to approve the registration of any person as a nurse under section 7(1), the Secretary shall immediately give written notice of that refusal to the person affected.

(3) A certificate of registration issued under subsection (1) shall be in such form as the Council approves and shall remain in force until it is suspended or cancelled by the Council.

Practising Certificate and annual registration.

10.(1) The Registrar shall, in respect of the registration of a person under section 7(1), issue to that person a certificate to be called a Practising Certificate.

(2) A nurse who desires to practise as such in Barbados in any year shall, in the month of January in that year, apply to the Registrar for a Practising Certificate, and the Registrar shall on payment of the prescribed annual registration fee issue to her a Practising Certificate.

(3) Where a nurse applies to the Registrar for a Practising Certificate in a month other than January, the Registrar shall on payment of the additional sum imposed by section 11 issue to her a Practising Certificate.

(4) A Practising Certificate is valid for the year in which it is issued and expires on the 31st January of the ensuing year.

(5) The annual registration fee payable under this Act becomes due and payable on the 1st January in each year.

Penalty for late payment of annual registration fee.

11. Any person required by section 10 to pay an annual registration fee who fails to pay such fee during the month of January in any year shall, in respect of her registration for that year, pay to the Registrar in addition to the registration fee payable under section 10 a sum equal to such fee.

Effect of refusal or failure to pay annual registration fee.

12. Any person who –

(a) is required by section 10 to pay an annual registration fee; and

(b) refuses or fails to pay such fee after one month from the date on which such fee becomes payable,

shall be treated as not being registered for the purposes of the Act.

Exemption of wholetime public officials from payments of registration fee.

13. No fee shall be payable in respect of registration under this Act of any person who is employed on a wholetime basis in the public service.

Additional qualifications.

14. A nurse who obtains a qualification approved by the Council as higher than or additional to that in respect of which she is registered is entitled without the payment of any fee to have such higher or additional qualification entered by the Registrar in the register in substitution for or in ad-

dition to, as the case may be, the qualification in respect of which she is registered.

Publication of lists of nurses.

15.(1) The Registrar shall cause to be published in the *Official Gazette* –

(a) in the month of February in every year an alphabetical list of persons who have at 31st January in that year registered their names as required by section 10;

(b) as soon as practicable after such registration the name of any person registering her name as a nurse after 31st January in any year.

(2) A copy of the *Official Gazette* containing the lists referred to in paragraph (a) of subsection (1) or the name of any person published pursuant to paragraph (b) of that subsection is *prima facie* evidence in any court of the registration and qualifications of any person mentioned in the lists or of the person, as the case may be, and such lists are *prima facie* evidence of the non-registration of any person whose name is not shown therein.

Part III

Midwives

Midwives' Register.

16. The Registrar shall keep a register to be known as the Midwives' Register.

Application of Part II.

17. Part II applies *mutatis mutandis* to the Midwives' Register as it applies to the Nurses' Register and to midwives as it applies to nurses.

Conditions as to registration of midwives.

18. The Council may attach such terms and conditions with respect to the registration of midwives as it thinks fit.

Duties of midwife in cases of emergency.

19.(1) Where it is reasonable to believe that a case of emergency involving a patient exists, a midwife shall –

(a) call a medical practitioner to her assistance; or

(b) cause the patient to be conveyed to a hospital,

and if the patient is certified by a Welfare Officer to be unable to pay any fee involved, such fee shall be paid out of moneys voted for the purpose by Parliament.

(2) The midwife shall immediately report to the Chief Medical Officer each such case of emergency, furnishing such information as the Chief Medical Officer requires.

(3) The Minister or a person authorised by him for the purpose may recover any fee paid under subsection (1) as a debt due to the Crown in Civil proceedings before a Magistrate for District "A", from the patient, husband or guardian of the patient.

Part IV

Nursing Assistants

Nursing Assistants' Roll.

20.(1) The Registrar shall keep a Roll to be known as the Nursing Assistants' Roll in which he shall cause to be entered the name of every person entitled to be enrolled as a nursing assistant together with the following particulars in respect of each such person –

(a) her full name and address;

(b) the date of her enrolment;

(c) a description and the date of qualification in respect of which she is enrolled.

(2) Subsections (3) and (4) of section 5 apply to the Nursing Assistants' Roll as they apply to the Nurses' Register.

First enrolment.

21(1) Any person who, after the commencement of this Act applies to the Council to be enrolled as a nursing assistant, and who satisfies the Council –

(a) that she is qualified to be so enrolled;

(b) that she is a fit and proper person to practise as a nursing assistant; and

(c) that she is of the prescribed age,

is entitled, upon compliance with the requirements of this Act and on payment of the prescribed fee, to be enrolled as a nursing assistant.

(2) For the purposes of subsection (1) a person is qualified to be enrolled as a nurisng assistant who –

(a) has completed a course of training approved by the Council; and

(b) has passed the prescribed examination.

(3) Notwithstanding subsection (2) a person who –

(a) prior to the commencement of this Act has been engaged in the practice of nursing under conditions which the Council considers satisfactory to establish her qualifications as a nursing assistant; or

(b) is registered, licensed or otherwise entitled to practise as a nursing assistant, a nurse aide or under any other

designation, the training for which is in the opinion of the Council equivalent to that of a nursing aide in Barbados,

may apply to the Council to be enrolled and the Council may in its absolute discretion require the applicant to submit to examination in such subjects as it considers necessary to establish that she possesses satisfactory training as a nursing assistant.

Application of sections 9 to 15.

22. Sections 9 to 15 apply *mutatis mutandis* to nursing assistants as they apply to nurses.

Part V

Miscellaneous

Examinations.

23.(1) For the purposes of any examination required under this Act, the Council shall appoint a Board of Examiners, in this section referred to as the Board, consisting of such persons as it thinks fit to set and conduct the examination in such subjects as the Council directs and to report its findings to the Council.

(2) The Council shall fix a time and place for holding the examination and the Secretary shall notify a candidate of that time and place.

(3) A candidate shall pay to the Secretary such examination fee as may be determined by the Council with the approval of the Minister.

(4) If, as a result of the examination, the Board finds that a candidate is sufficiently informed and skilled in the subjects in which she was examined, she shall be deemed, on the receipt by the Council of the report of such findings, to have satisfied the Council that she is qualified to be registered under this Act.

(5) Where the Board reports to the Council that a candidate is unsuccessful in the examination,

she shall not, unless the Board so recommends, be permitted to present herself for further examination until the expiration of 6 months from the date of the examination in which she is unsuccessful.

(6) A candidate who is unsuccessful in an examination under this section, shall before being permitted to sit for further examination, comply with such conditions as the Council directs including the payment to the Secretary of such further fee as may be determined by the Council with the approval of the Minister.

(7) Members of the Board shall for each examination receive such fees as may be determined by the Council with the approval of the Minister.

Disciplinary proceedings.

24.(1) A nurse, midwife or nursing assistant who –

(a) is convicted of an offence outside Barbados which if committed in Barbados would be punishable on indictment; or

(b) is convicted of such offence in Barbados; or

(c) is alleged to be guilty of professional misconduct,

is subject to disciplinary proceedings.

(2) If, in any such proceedings, the Council is satisfied that a nurse, midwife or nursing assistant is convicted of an offence under paragraph (a) or (b) of subsection (1) or that she is guilty of professional misconduct, it may –

(a) censure her;

(b) suspend her registration or enrolment, as the case may be, for a period not exceeding one year;

(c) direct the Registrar to remove her name from the Register or Roll, as the case may be.

Suspension from practice pending disciplinary proceedings.

25. If in the opinion of the Council it is expedient or dangerous or against the public interest or not in the interest of the health of a patient that a nurse, midwife or nursing assistant should continue to practise pending the institution of disciplinary proceedings, the Council may suspend the registration of such nurse or midwife, or the enrolment of such nursing assistant, as the case may be.

Secretary to notify Registrar of Council's decision to suspend registration of enrolment or to remove name from register or roll.

26. Where the Council under section 24 or 25 suspends the registration of a nurse or midwife, or the enrolment of a nursing assistant, or under section 24 directs the removal of her name from the register or roll, the Secretary shall immediately give written notice to the Registrar of that suspension or direction.

Restoration of name to register or roll and publication in *Official Gazette.*

27.(1) The Council may, at any time, direct the Registrar to restore to the register or roll, as the case may be, the name of any person removed therefrom under section 24(2).

(2) When the name of any person is removed from the register or roll, as the case may be, the Council may, in writing require such person to return to the Council her certificate of registration or enrolment, as the case may be, and such person shall comply with that requirement.

(3) The Registrar shall, as soon as practicable after receiving a notice under section 26 or a direction under section 27(1), cause a notice thereof to be published in the *Official Gazette.*

Secretary to notify person affected by Council's decision under section 24(2).

28. The Secretary shall immediately give written notice to the person affected by a decision of the Council under section 24(2) to –

(a) censure her;

(b) suspend her registration or enrolment; or

(c) direct the Registrar to remove her name from the register or roll.

Appeals.

29.(1) Subject to subsection (4) any person who is aggrieved by refusal of the Council to register or

enrol her under this Act or by its decision to censure her or suspend her registration or enrolment as the case may be, or cause her name to be removed from the register or roll, as the case may be, may, within 3 months of the receipt by her of any such notice, appeal to a Judge in chambers whose decision shall be final.

(2) The Council may, pending an appeal under subsection (1) of any person aggrieved by its decision to suspend her registration or enrolment, as the case may be, or cause her name to be removed from the register or roll, as the case may be, on the application of that person, suspend the operation of any such decision until the determination of the appeal.

(3) The Judge may –

(a) on the hearing of an appeal against refusal of registration or enrolment, dismiss the appeal or allow the appeal and direct the Council to cause the registration or enrolment to be effected;

(b) on the hearing of an appeal other than an appeal against refusal of registration or enrolment, as the case may be –

(i) dismiss the appeal and confirm the decision of the Council, or

(ii) allow the appeal and set aside the decision of the Council, or

(iii) allow the appeal and direct that the disciplinary proceedings in respect of which the decision of the Council is made be reconducted by the Council, or

(iv) set aside the penalty imposed by the Council and impose in substitution therefor such other penalty under section 24(2) as he thinks fit.

(4) Notwithstanding subsection (1) no appeal shall be made under this section against refusal of an application for registration or enrolment, as the case may be, in a case in which such registration or enrolment is conditional upon the applicant's satisfying the Council that she is qualified to be registered or enrolled as the case may be.

Rules and Regulations.

30.(1) Subject to the approval of the Minister, the Council may make rules for any of the following purposes –

(a) the proper conduct of its affairs including the time, manner and place of meeting and the proceedings thereof;

(b) prescribing the conditions and qualifications for the admission to training of persons as nurses, midwives or nursing assistants;

(c) prescribing syllabuses of study and programmes of training to be followed at recognised places of training or affiliated places of training in respect of nurses, midwives and nursing assistants:

(d) prescribing the fees to be paid by candidates for, and regulating the conduct of, examinations to be passed as a condition of admission to registration as a nurse or midwife, as the case may be, or enrolment as a nursing assistant;

(e) regulating and defining the nature of the services to be performed by nurses, midwives and nursing assistants;

(f) prescribing the minimum number of hours of instructions constituting the course of training for nursing assistants;

(g) providing for enrolment as nursing assistants of persons trained or partly

trained as such outside Barbados and the conditions for such enrolment;

(h) the conduct of examinations and matters relating thereto and the fees to be paid for such examinations;

(i) the determination of professional conduct and general fitness to practise as a nurse, midwife or nursing assistant, as the case may be;

(j) the institution of disciplinary proceedings in relation to any charge under section 24 and the manner in which such proceedings are conducted;

(2) Without prejudice to subsection (1), the Minister may make regulations generally for carrying out the provisions of this Act and for any of the following purposes –

(a) prescribing the fees to be paid for registration or enrolment and the fees to be paid annually for any of the purposes of this Act;

(b) prescribing anything not mentioned in subsection (1) that is by this Act required to be prescribed.

Badges and uniforms.

31. The Council may approve the letters or symbols indicating the registration or enrolment, as the case may be, of a nurse, midwife, or nursing assistant.

Offences.

32.(1) Any person who, for the purpose of procuring or attempting to procure the registration or enrolment under this Act, as the case may be, of herself or for any other person, makes or produces or causes to be made or produced any fraudulent representation or declaration either verbally, in writing or otherwise, is guilty of an offence and liable on summary conviction to a fine not exceeding $500 or to imprisonment for a term not exceeding 3 months or both.

(2) A person, not being a nurse, midwife or nursing assistant, who –

(a) assumes or uses any name, title or description implying that she is entitled to be recognised or to practise;

(b) advertises or holds herself out as a person authorised or qualified to practise; or

(c) practises,

as a nurse, midwife or nursing assistant, as the case may be, is guilty of an offence under this Act and liable on summary conviction to a fine not exceeding $500 or to imprisonment for a term not exceeding 3 months or both.

Performance of nursing or midwifery services in cases of emergency.

33. Nothing in this Act prevents a person from performing in cases of emergency nursing or midwifery services without hire, gain or hope of reward.

Exemption from liability.

34. Nothing done by any member of the Council, the Secretary or any person acting under the authority of either of them, shall, if such thing was done *bona fide* for the purposes of this Act or the regulations, subject any such person to any action, liability, claim or demand.

Recovery of unpaid registration or enrolment fees.

35. Without prejudice to sections 11 and 32(2) any registration or enrolment fee payable under this Act which remains unpaid for one month from the date on which such fee becomes payable may be recovered as a debt due to the Crown in Civil proceedings before a Magistrate for District "A".

Payment of fees into Consolidated Fund.

36. All fees collected by the Registrar or Secretary under this Act shall be paid into the Consolidated Fund.

Expenses.

37. Any expenses incurred by the Council in the performance of its functions under this Act and regulations shall be defrayed out of moneys voted for the purpose by Parliament.

Repeal of Act 1932–1.

38. The Midwives and Nurses Registration Act, 1932 is repealed.

Commencement.

39. This Act shall come into operation on such day as the Governor-General may appoint by proclamation.

SCHEDULE

(Section 3)

1. Subject to paragraph 3, the General Nursing Council shall consist of -

(a) the following persons *ex officio*
  (i) the Chief Medical Officer;
  (ii) six persons to be appointed by the Minister from among those officers in the Government Service who hold the most senior posts in the Nursing Administration and Nursing Education;

(b) 4 members of the Registered Nurses Association appointed by the Minister on the nomination of the Association;

(c) 1 member of an association of medical practitioners approved by the Minister and appointed by the Minister on the nomination of that association; and

(d) 1 senior technical officer of the Ministry of Education appointed by the Minister of Education.

2. The Council may -

(a) appoint such committees composed of members of the council and persons not being members of the council nor registered or enrolled under this Act, for the proper carrying out of its functions;

(b) delegate to such committees any functions it considers necessary.

3.(1) Members of the Council other than *ex officio* members shall hold office for 2 years but are eligible for re-appointment.

(2) Notwithstanding paragraph (1) no member other than an *ex officio* member shall hold office for more than 2 consecutive terms but such member is eligible for re-appointment after the expiration of 1 year thereafter.

4. (1) The Minister shall appoint a member of the Council to preside as chairman of the first meeting of the Council.

(2) The Council shall elect from among its members a chairman and deputy chairman for a term of 2 years and each such person shall be eligible for re-election.

(3) In the absence of the chairman or deputy chairman, the Council shall elect one of the members present to be chairman of that meeting.

5. 5 members of the Council shall form a quorum.

ANNEX C

The Nurses and Midwives Rules, 1973
section 18(1) (Barbados)

18. (1) A midwife may in the course of her duties

(a) administer orally, or by subcutaneous or intramuscular injection or by inhalation as may be appropriate, analgesics, oxytocics and sedatives (including those with a tranquillising effect);

(b) suture perineal tears of the first degree;

(c) prescribe dietary supplements;

(d) in cases of grave emergency only –

(i) perform an episiotomy for the relief of maternal or foetal distress;

(ii) remove a placenta manually;

(iii) in multiple births, perform external version and artificial rupture of the membranes;

(iv) administer intravenously electrolyte solutions, plasma, plasma substitutes or oxytocics.

(2) A midwife may not –

(a) administer any anaesthetic substance except by inhalation from a machine approved in writing by the Chief Medical Officer for the use of midwives;

(b) administer any blood transfusion except in accordance with the written instructions of a registered medical practitioner;

(c) perform internal version; or

(d) perform any instrumental delivery.

Functions of registered midwives

29.(1) The functions of registered midwives shall be

(a)(i) to administer barbituates and other sedatives, including those with a tranquilizing effect, narcotics, oxytocics, and analgesics whether orally, by inhalation, or by injection; and

(ii) to induce labour by medication; under the direct supervision of a registered medical practitioner;

(b)(i) to administer ergometrin, bromide and analgesics whether orally, by inhalation, or by intra-muscular injection;

(ii) to prescribe dietary supplements such as iron, calcium, vitamins and milk protein supplements;

(iii) to induce labour by administering oil, enema and bath; and

(iv) to perform suture of perineal tear of the first degree

on her own initiative and judgement;

(c)(i) to perform an episiotomy to relieve maternal or foetal distress;

(ii) to remove placenta manually;

(iii) to perform, in multiple births, external version and artificial rupture of the membrane; and

(iv) to administer a saline or electrolyte solution, intradex or ergometrin intravenously

in cases of grave emergency.

(2) Notwithstanding anything contained in paragraph (1) of this regulation, a registered midwife shall not –

(a) administer anaesthetics –

(i) by inhalation except by an anaesthetic machine approved by the Minister in writing for the use of midwives;

(ii) intravenously;

(iii) by local application or pudental block;

(b) except in accordance with the written order of a registered medical practitioner, administer blood transfusions;

(c) perform internal version;

(d) perform delivery by forceps or vacuumextractor.

ANNEX D

NURSES' BOARD FOR GHANA

DETAILS OF THE PRACTICE OF NURSES AS PERMITTED UNDER SECTION 10 (1) (K) OF THE NURSES' ORDINANCE, No. 20 OF 1966

SCHEDULE 8. (*Regulations* 29, 30, 31 and 32)

PRACTICE OF NURSES

Treatments which a Nurse may perform without Instructions from a Doctor

1. Care and cleanliness of all nursing equipment.
2. Sterilization of surgical equipment.
3. Washing of patient.
4. Prevention and treatment of bedsores.
5. Cleaning patient of pediculi.
6. Making of patient's bed.
7. Cooking and serving patient's food.
8. Cleaning mouth of patient. Administration of mouth washes and gargles.
9. Giving treatments for reduction of pyrexia, tepid and cold sponging but not administration of anti-pyretic drugs, except aspirin, phenacetin.
10. Administration of evacuant enemata, soap and water, olive oil, glycerine.
11. Administration of evacuant suppository, viz. glycerine but not of suppositories containing dangerous drugs or poisons.
12. Administration of the following aperients; (Saline) Mist Alba, Magnesium Sulphate, Sodium Sulphate, Potassium Tartrate or any proprietary preparation of these.

    (Vegetable) Cascara Sagrada, Senna or proprietary preparations containing these.

    Mineral Oils, Liquid Paraffin.

    Note.—A nurse may not administer cathartics without sanction of Doctor.
13. Administration of antacid drugs for relief of gastric pains—Sodium bi-carbonate, carbonate, magnesium trisilicate, aluminium hydroxide or proprietary preparations of these.
14. Administration of drugs for relief of flatulence: Peppermint.
15. Administration of common drugs for the relief of pain—aspirin, but not of any drug listed in the Dangerous Drugs Ordinance or Poisons Schedules.

16. Giving of moist inhalation for laryngitis, tracheitis, pharyngitis, or nasal sinus infections.

17. Application of simple liniments.

18. Irrigation of eyes.

19. Application of cold to a part—cold compress, ice bag.

20. Application of heat to a part—hot water bottles, electric pad, medical fomentation, turpentine stupe, soda stupe but not belladonna or opium stupes.

21. Surgical fomentation.

22. Application of cataplasm or poultice to painful part—Cataplasma Kaolini Co.

23. Make blood films for diagnosis of malaria. (The nurse may not, without sanction of a Doctor, withdraw blood through a hollow needle or any other contrivance for the purpose of making blood tests.)

24. Disinfection of utensils, clothing, bedding, furniture, excreta of patients.

25. Give usual nursing and first aid treatments for relief of shock. —Warmth; elevation of legs; rectal saline with glucose.

26. Withdraw urine by catheter; (Qualified Mental Nurse may only use Rubber Catheter.)

27. Arrest haemorrhage by use of pad and bandage, digital pressure or tourniquet.

28. Give first aid treatment for cleaning of a wound.

29. Apply first aid to fractures, sprains, muscle injuries, by using splints, slings, bandages or sandbags.

30. Performance of artificial respiration in an emergency.

31. First aid treatment for removal of foreign body from eye.

32. Giving of first aid treatment for snake bite or insect stings.

33. Giving of first aid to a woman in labour if no midwife or Doctor is available.

34. Giving of first aid to patients having fits or convulsions.

35. Administration of demulcent drinks; common antidotes and antagonists against poisons and administration of such stimulants as coffee in cases of collapse following poisoning.

36. Giving first aid treatment for burns but not applying Sclerosing agents to burnt areas without sanction of Doctor.

37. Performance of last offices.

38. Keeping of the various charts.

Treatment which a Nurse may perform only with Sanction of a Registered Medical Practitioner (not necessarily in His Presence), given in writing and dated on the patient's Treatment form

39. Artificial feeding by oesophageal or nasal routes.

40. Administration of any drug ordered by a Registered Medical Practitioner.

This includes: —

Oral administration.
Rectal Administration.
Hypodermic injection.
Intra-muscular injection.
Intravenous injection (but not intravenous administration of blood, plasma).
Applications to eyes.
Applications to ears.
Applications to throat.
Applications to vagina.
Applications to urethra.
Applications to skin.
Administration by inhalation (but not anaesthetics except in the presence of a Registered Medical Practitioner).
A nurse may not administer drugs or anaesthetics by the intra-thecal route.

41. Obtaining of specimens of infective material from throat, nose, eyes, urethra, cervix, using appliances for the purpose.
42. Examination of urine with a view to providing data for doctor to form a diagnosis.
43. Preparation for major operations on any part of the body, except in an emergency.
44. Performance of minor operations such as incision of boils or insertion of sutures in wounds.
45. Application of strapping or elastoplast or other skin adherent for temporary treatment of fractures. Putting on of Plaster of Paris.
46. Application of radiant heat, except in an emergency.
47. Performance of diaphoretic treatment such as hot packing.
48. Blistering and cupping.
49. Lavage of stomach, colon, bladder.
50. Vaginal douching.
51. Dressing of operation and other wounds including removal of stitches, clips, drainage tubes, etc.

Treatment which Nurses may Perform only in Presence of a Registered Medical Practitioner and with his Sanction.

52. Administration of anaesthetics.

Suggested Primary Health Care Tasks for Paramedicals*

1. Medical Care Paramedicals

   1. Screen patients for referral care.
   2. Take patient history, examine, diagnosis and prescribe.
   3. Render treatment including injections and dressings.
   4. Provide elementary nursing.
   5. Attend to in-patients.
   6. Suture wounds.
   7. Reduce dislocations and splint simple fractures.
   8. Perform minor out-patient surgery.
   9. Administer local anaesthetics.
   10. Extract teeth.
   11. Perform catheterization.
   12. Diagnose common eye diseases.
   13. Diagnose common ear, nose and throat diseases.
   14. Vaccinate.
   15. Immunize.
   16. Sterilize equipment and dressing.
   17. Diagnose and treat selective mental diseases.
   18. Diagnose and treat selective dental diseases.
   19. Diagnose and treat malnutrition, including rehydration.
   20. Perform vasectomy.
   21. Counsel patients.
   22. Issue, complete and file case notes and cards.
   23. Instruct patients in family planning methods (male particularly)
   24. Maintain surgery in clean and aseptic conditions.
   25. Account, record and inventory supplies.

* Adapted from Siraj-ul-Haq and Fendall, Primary Health Care in Rural Areas of Pakistan, pp. 20-22 (Islamabad: Planning Commission, Government of Pakistan, 1974).

26. Visit and treat patients at home.

27. Undertake follow-up visiting.

28. Render first aid.

29. Perform resusicitation.

30. Manage epileptiform convulsions.

31. Administer the health unit.

32. Organize referral clinics and carry out the instructions of the professional staff.

33. Render reports as instructed.

34. Examine urine and stools, stain and examine blood slides and sputum for A.F.B.

35. Take blood pressure.

II. Midwife-Paediatric Paramedicals

A. Midwifery

1. Organize maternity clinics.

2. Perform antenatal and postnatal examination.

3. Vaginal and rectal examination.

4. Attend to normal deliveries.

5. Diagnose and treat peuperal infections.

6. Take blood pressure.

7. Examine urine.

8. Measure haemoglobin - Talquist.

9. Diagnose and treat common complications of pregnancy including pre-eclampsia.

10. Suture 1st and 2nd degree tear.

11. Administer local anaesthetic.

12. Manage A.P.H.

13. Manage P.P.H.

14. Manage minor obstetrical complications and emergencies.

15. Recognize and refer gynaecological abnormalities.

16. Recognize and refer obstetrical abnormalities.

17. Take care of the maternity cases admitted for observations, delivery or referral.

B. Infant and Child Care

1. Organize infant and child care clinics.

2. Diagnose and treat common infant ailments.

3. Diagnose and treat common childhood diseases.

4. Organize and manage well-baby clinics.

5. Perform vaccinations.

6. Perform immunizations.

7. Diagnose and treat malnutrition.

8. Undertake nutrition counselling.

C. Family Planning

1. Conduct and organize family planning clinics.

2. Advise and instruct on family planning methods.

3. Screen and refer clients.

4. Insert I.U.D.

5. Issue oral contraception and monitor clients.

6. Motivate clients and community.

7. Provide follow-up services to acceptors.

8. Make home visits and counsel.

D. General

1. Undertake family and community counselling.

2. Issue, complete and file case notes.

3. Note, check, prepare and transmit routine reports.

4. Sterilization of equipment and dressing.

5. Management of wards for maternity (where appropriate).

6. Care of the handicapped children.

7. Care of the aged and infirm.

III. Communicable Disease Auxillary

1. Diagnose and treat common infectious and vector borne diseases.
2. Perform vaccinations.
3. Perform immunizations.
4. Maintain epidemic surveillance.
5. Undertake community epidemic prevention and control.
6. Carry out specific disease control programmes under instructions e.g. tuberculosis, smallpox, malaria, leprosy and trachoma.
7. Carry out community survey - epidemiological and local.
8. Record births and deaths and collect and maintain records of other vital statistics as instructed.
9. Undertake the village census.
10. Undertake sanitary survey e.g. water supply, housing and conservancy.
11. Undertake school health surveys.
12. Undertake school medical clinics.
13. Prepare case findings and provide defaulter tracing and retrieval regarding communicable diseases.
14. Counsel on family and community communicable disease.
15. Counsel and motivate community on family planning.
16. Advise and instruct on family planning methods (male particularly).
17. Perform vasectomies.
18. Advise, instruct and perform simple improvements in village sanitary conditions (water, conservancy, housing and pest control).

I assent.

[L.S.] G. K. CAKOBAU

Governor-General

5th October 1978

AN ACT

TO MAKE PROVISION FOR THE REGISTRATION AND CONTROL OF MEDICAL ASSISTANTS

[1st January 1978]

ENACTED by the Parliament of Fiji—

1. This Act may be cited as the Medical Assistants Act, 1978 and shall be deemed to have come into force on the 1st day of January, 1978. Short title.

2. In this Act, unless the context otherwise requires— Interpretation.

" appropriate form " means a form approved by the Minister for use in any particular case pursuant to this Act;

" Council " means the Medical Assistants Registration Council established under section 3;

" medical assistant " means a person who has been granted a certificate under section 4;

" Permanent Secretary " means the Permanent Secretary for Health;

" Secretary " means the Secretary to the Council.

3.—(1) For the purposes of this Act, there shall be established a Medical Assistants Registration Council. Establishment of Medical Assistants Registration Council.

(2) The Council shall consist of—

(*a*) the Permanent Secretary who shall be Chairman;

(*b*) a senior professional medical officer of the Ministry of Health appointed by the Minister;

(*c*) the Principal of the Fiji School of Medicine; and

(*d*) two medical assistants appointed by the Minister.

(3) The Minister shall appoint a suitable person to be Secretary to the Council.

(4) Three members shall constitute a quorum at any meeting of the Council.

(5) Subject to the provisions of this Act the Council may regulate its own procedure and may make rules for that purpose.

(6) The Council shall cause proper records of its proceedings to be kept.

Requirements for registration.

4. A person in possession of a certificate in the appropriate form granted by the Fiji School of Medicine (hereinafter referred to as "the School") certifying that he has—

(*a*) attended an approved course of study as a medical assistant at the School for a period of not less than three years;

(*b*) passed to the satisfaction of the School approved examinations; and

(*c*) satisfied the School of his ability to practise as a medical assistant in the service of the Government subject to such regulations as may be made under this Act,

shall be entitled to make application to the Council for registration as a medical assistant.

Register to be kept.

5—(1) The Council shall form and maintain a register in which shall be entered the names of all persons registered as medical assistants.

(2) The Secretary shall in the month of January in each year cause to be published in the Gazette a list of the names of the persons registered in the register.

Limitation on practice.

6. No medical assistant shall practise medicine except in the service of Government.

Prescriptions. Cap. 96 (Cap. 114).

7. Notwithstanding the provisions of the Pharmacy and Poisons Act, but subject to any limitations or restrictions which may be imposed by the Permanent Secretary, a medical assistant may issue prescriptions and dispense any medicine or drug.

Misconduct.

8.—(1) If any person who is registered as a medical assistant is after due inquiry, at which inquiry such person shall be entitled to be heard, adjudged by the Council to have been guilty of professional misconduct the Council may, if it sees fit, order that the name of any such person be deleted from the register and the Chairman of the Council shall forthwith delete that name and the Secretary shall notify the person affected.

(2) Notwithstanding the provisions of subsection (1), the Council may, instead of ordering that the name of any person be deleted from the register issue a reprimand or warning to such person.

(3) In directing that a person's name shall be deleted from the register the Council may, if it sees fit, specify a period on the expiration of which such person may again apply to be registered under the provisions of this Act.

(4) An order made by the Council under this section shall not take effect in any case until the expiration of 30 days after the date of the order and if, within that period, the person affected gives notice of his intention to appeal against the order, shall not take effect until and unless it is confirmed by a resident magistrate or the appeal is for any reason dismissed by such magistrate.

Appeals.

9. Any person whose application for registration under the provisions of section 4 is refused or whose name has been deleted from the register under the provisions of section 8 may within 30 days of notification to him of such refusal or deletion appeal to a resident magistrate and on any such appeal the resident magistrate may make such order as he thinks proper having regard to the merits of the case and the public welfare.

Penalty.

10.—(1) No person shall be entitled to take or use the name or title of medical assistant or any name title, addition or description implying that he is registered under this Act unless he is so registered.

(2) Any person not being registered under this Act who takes or uses any such name title, addition or description as aforesaid shall be guilty of an offence and shall be liable on conviction to a fine not exceeding five hundred dollars or to imprisonment for a period not exceeding one year or to both such fine and imprisonment.

Penalty for obtaining registration by false pretences.

11. Every person who wilfully procures or attempts to procure himself to be registered under this Act by making or producing or causing to be made or produced any false or fraudulent representation or declaration either verbally or in writing, shall be guilty of an offence and shall be liable on conviction to a fine not exceeding five hundred dollars or to imprisonment for a period not exceeding six months or to both such fine and imprisonment.

Regulations.

12. The Minister may make regulations—

(*a*) imposing conditions and restrictions on practising by medical assistants; and

(*b*) generally for the better carrying out of the provisions of this Act.

Passed by the House of Representatives this seventeenth day of August in the year of our Lord one thousand, nine hundred and seventy-eight.

Passed by the Senate this twenty-sixth day of September in the year of our Lord one thousand, nine hundred and seventy-eight.

Price : 20c I. Ravutu, Government Printer, Suva, Fiji—1978 11 Z 78—1,400

ANNEX F

IN THE HIGH COURT, KUMASI

29th March, 1962

APALOO, J.

THE STATE *v.* KWAKU NKYI

Criminal law—Manslaughter—Negligence—Practising medicine without being registered—Medical and Dental Act, 1959, *s.* 23 (1).

The accused, a student nurse, was asked to treat a sick child. He agreed to do so, and injected the child twice with what he believed was mepacrine. The child's condition immediately deteriorated and he died within a few hours. *Post mortem* examination revealed that death was due to arsenic poisoning. The accused was charged with manslaughter and with practising medicine without being registered.

Held: (1) the negligence of the accused in mistaking arsenic for the drug he intended to administer did not amount to a reckless disregard for human life. *R.* v. *Ezeocha* (1946) 12 W.A.C.A. 56 distinguished;

(2) his conduct brought him within the mischief which the Medical and Dental Act, 1959, s. 23 (1) seeks to prevent.

Cases referred to:
(1) *R.* v. *Awonu* (1946) 12 W.A.C.A. 95
(2) *R.* v. *Mensah* (1948) 12 W.A.C.A. 346
(3) *Andrews* v. *D.P.P.* [1937] A.C. 576
(4) *R.* v. *Bateman* (1925) 19 Cr. App. R. 8
(5) *Akerele* v. *The King* (1942) 8 W.A.C.A. 5, P.C.
(6) *R.* v. *Ezeocha* (1946) 12 W.A.C.A. 56

TRIAL of accused before judge and assessors for manslaughter and practising medicine without being registered contrary to the Medical and Dental Act, 1959, s. 23 (1).

A. K. Gikunoo for the prosecution.
Accused in person.

Apaloo, J. In this case, there is a comfortable area of agreement between the case of the prosecution and defence. The accused was at the material time a student nurse at the Central Hospital, Kumasi. He was described by Mr. Doku (P.W.6) as a good student and well behaved. Working in the same hospital, was Adongo Frafra who was employed there as a labourer. It seems from the evidence that he knew the accused well and they both appear to get on well together. Adongo Frafra also had in town a cousin by name Akwaba Frafra.

It is established by the evidence that about one week before the 12th December, 1960, Akwaba's two-year old son by name Asamprana was taken ill. It is said he had a cough and temperature. Accordingly, Akwaba asked Adongo whether he could get some one in the hospital to come round and have a look at the boy. Adongo got in touch with the accused. I am satisfied that the accused agreed to go to Akwaba's house and treat the child. Both the accused and Adongo went to Akwaba's house reaching there about 3 p.m. on the 12th December, 1960. I find the accused took with him a syringe and a drug which turned

out to be arsenic. After being told the nature and the history of the illness, accused injected each side of the child's buttocks with the said drug. I accept the evidence that the accused was asked what fee he would charge for his services. He said one pound. This was promised to be sent to him the next day. Both the accused and Adongo then left Akwaba's house.

As soon as they left, the child's sickness took a turn for the worse. He screamed seriously, began to tremble and there was foam in his mouth. Akwaba quickly handed the child to his mother Alufuah and went out to fetch back the accused. Before he returned, the child died in his mother's arms. The dead body was rushed to hospital in a taxi. At 1 p.m. the following day, Dr. Joshin, the pathologist, performed a *post mortem* examination on the dead child. As he was unable to arrive at a conclusion as to the cause of death he incised the two sides of the child's buttocks which were injected and forwarded these to the government chemist together with the stomach, liver, kidneys and a piece of brain. On the basis of the chemist's report, Dr. Joshin expressed as his opinion that Asamprana's death was due to acute arsenic poisoning.

The prosecution's case if I understand it aright is that Asamprana's death was caused by harm, which harm resulted from the accused's negligence. The negligence consisted in the fact that the accused who is not a qualified medical man took it upon himself to treat a sick child. In doing so, he used a dangerous drug without skill with the result that the patient died. Although I feel no doubt that the accused mistook arsenic for mepacrine due to their similarity in colour, had he been more skilful than he in fact is, he could have distinguished between the two. In my opinion, his voluntary assumption of the treatment of Asamprana without necessary skill, as he well knew, is itself evidence of negligence.

In the cases of *R.* v. *Awonu*[1] and *R.* v. *Mensah*[2] it was decided that the law of negligence in this country was more widely defined than in the case of England and Nigeria and that section 14 (1) of the Criminal Code[3] appeared to have codified the law relating to civil negligence then in England. It was accordingly held that cases like *Andrews* v. *D.P.P.*,[4] *R.* v. *Bateman*[5] and *Akerele* v. *The King*[6] which laid down the degree of negligence which would suffice to establish manslaughter by negligence, were inapplicable in this country. These cases establish that in order to found criminal liability based on negligence, the negligence must be gross and must pass beyond a mere matter of carelessness and show such disregard for life and safety as to amount to a crime against the State. The position therefore was that from the point of view of an accused person the law of criminal negligence in England was more liberal than the law then in this country. These cases of *Awonu* and

[1] (1946) 12 W.A.C.A. 95.
[2] (1948) 12 W.A.C.A. 346.
[3] Cap. 9 (1951 Rev.).
[4] [1937] A.C. 576.
[5] (1925) 19 Cr. App. R. 8.
[6] (1942) 8 W.A.C.A. 5, P.C.

Mensah to which I have referred were decided in 1946 and 1948 respectively. In 1950, the law of manslaughter by negligence in this country was made more conformable to the law of England by a proviso that the negligence to found a charge of manslaughter must amount to a reckless disregard for human life. The result of this amendment is to equate the law relating to criminal negligence in this country to the law of England.

As I have said, the fact that the accused was negligent is plain enough but I cannot find on the evidence that such negligence was gross or amounts to a reckless disregard for human life. At least in one sense at any rate, the accused in responding to Adongo's invitation and proceeding to Akwaba's house with a view to attending to his sick child, showed anxious regard for human life. In my judgment, it would not be right to hold that the accused's negligence amounts to a reckless disregard for human life simply because possibly out of inadvertence or want of care, he mistook the drug that he intended to administer to the sick child. In my opinion, this case is distinguishable from *R.* v. *Ezeocha*[7] in which the West African Court of Appeal held that a native doctor who administered bismuth to a patient causing her toxaemia from which she died was guilty of criminal negligence on the ground that while in that case the accused intended to administer a dangerous drug, the accused in this case mistook a dangerous drug for a perfectly harmless one. There is also the fact that in *Ezeocha's* case,the native doctor appears to be a wholly untrained person, whereas the accused in this case was a student nurse and was no novice at administering injections. Accordingly, I hold that the prosecution has failed to show that the proved negligence of the accused amounts to a reckless disregard for human life. I therefore share the unanimous opinion of the assessors and find the accused not guilty of manslaughter and acquit him on count one.

With regard to the second count, it seems to me that the accused brought himself precisely within the mischief which section 23 (1) of the Medical and Dental Act, 1959.[8] seeks to prevent. As the accused himself admits, he proceeded to Akwaba's house on the day in question with the object of treating his sick child and for this purpose, carried with him a syringe and a drug which turned out to be arsenic. In administering this drug to the sick child, the accused clearly practised medicine within the meaning of the section. The accused as he himself admits, is a student nurse and is not a registered medical practitioner and accordingly committed an offence against section 23 (1) of the Medical and Dental Act, 1959. I find him guilty of that offence and convict him on count two of the indictment.

Acquitted on count one.
Convicted on count two.

[7] (1946) 12 W.A.C.A. 56.
[8] Act 36/1959.

ANNEX G

More than a few medical practice statutes in the Commonwealth contains sections which either permit individuals who possess special licences to provide medical care or exempt special classes of individuals from the sanctions imposed under those statutes. Samples of these are found below.

Special Licences

Medical Practitioners and Dentist Act sections 13 and 14 (Kenya)

Licensing of persons to render medical or dental services.

13. (1) Notwithstanding any of the other provisions of this Act, the Board may, if it is satisfied that it is in the public interest to do so, confer upon any person who is not otherwise eligible to be registered as a medical practitioner or as a dentist under the provisions of this Act, by the issue, under the signature of the Director of Medical Services, of a licence to do so, the right to render medical or dental services.

(2) Every such licence shall be for such period and may contain such conditions as the Director of Medical Services shall, with the consent or on the instruction of the Board, impose.

(3) Any licence issued under this section may be cancelled or revoked and withdrawn at any time by the Director of Medical Services with the consent or on the instructions of the Board.

Effects of registration and licence under section 13.

14. (1) Registration as a medical practitioner or a dentist under this Act, or the granting of a licence under section 13 of this Act, shall only entitle the person so registered or so licensed to practise medicine or dentistry or to render medical or dental services, as the case may be, in a salaried post under a Government or Local Government health scheme or in such salaried posts in such institutions as the Board may from time to time approve.

(2) No medical practitioner or dentist shall act as or engage in private practice as a private practitioner or may be employed by a private practitioner, unless he holds a licence to engage in private practice under the provisions of section 15 of this Act.

Medical Ordinance, section 31 (Sri Lanka)

Where a person, who is not qualified to be registered under section 29 (1), is certified, by written statement given under the hand of the Director of Health Services and lodged with the registrar, to be in the employment of the Government of Sri Lanka as a medical officer, such person shall be deemed to be a duly registered medical practitioner, while he is so employed.

Special Exemptions

Medical Practitioners and Dentists Act
section 25 (Ghana)

Any person who wilfully and falsely takes or uses any name, title or addition implying a qualification to practise medicine or surgery or dentistry, or, not being registered or licensed under this Act or entitled under section 21 of this Act to the privileges of persons registered under this Act, practises or professes to practise or publishes his name as practising medicine or surgery or dentistry, shall be guilty of an offence and liable to a fine not exceeding three thousand shillings, or in default of payment to imprisonment for a term not exceeding twelve months.

Provided that nothing in this section contained shall make it an offence for any person in the service of:

(i) the Medical Department of the Government; or

(ii) any hospital, dispensary or similar institution which the Director of Medical Services, by notice in the Gazette, declares to be an approved institution for the purposes of this section;

to render medical assistance in the course of his duties in such service.

Medical Practitioners and Dentists Act
section 22 (Kenya)

Penalty for unregistered and unlicensed person practising.

22. Any person who wilfully and falsely takes or uses any name, title or addition implying a qualification to practise medicine or surgery or dentistry, or, who, not being registered or licensed under this Act, practises or professes to practise or publishes his name as practising medicine or surgery or dentistry or who, not being licensed under section 15 of this Act, practises as a private practitioner, shall be guilty of an offence and liable to a fine not exceeding ten thousand shillings, or in default of payment to imprisonment for a term not exceeding twelve months:

Provided that nothing in this section contained shall make it an offence for any person in the service of—

(i) the Medical Department of the Government; or

(ii) any hospital, dispensary or similar institution which the Director of Medical Services, by notice in the Gazette, declares to be an approved institution for the purposes of this section,

to render medical assistance in the course of his duties in such service or for a person to carry out treatment under the direction, supervision and control of a medical practitioner or a dentist or of a person licensed under section 13.

Medical Practitioners and Dentists Act section 26 (Kenya)

Nothing contained in this Act shall prohibit or prevent the practice of systems of therapeutics according to African or Asian method of persons recognized by the community to which they belong to be duly trained in such practice.

Provided that nothing in this section shall authorize any person to practice any African or Asian system of therapeutics except amongst the community to which he belongs, or the performance of an act on the part of any persons practising any such system which is dangerous to life of the giving of an injection by any person practising any such system.

BERMUDA

1973 No. 51

THE PROFESSIONS SUPPLEMENTARY TO MEDICINE ACT 1973

[Date of Assent 25th June, 1973]

[Operative Date 1st June, 1974]

WHEREAS it is expedient to provide for the establishment of a Council and Boards for certain professions supplementary to medicine; to provide for the registration of members of those professions, for regulating their professional qualifications and professional conduct, for cancelling registration in cases of misconduct, and for purposes connected with the matters aforesaid:

Be it enacted by The Queen's Most Excellent Majesty, by and with the advice and consent of the Legislative Council and the House of Assembly of Bermuda, and by the authority of the same, as follows:—

PART I
PRELIMINARY

Interpretation.

1. (1) In this Act, unless the context otherwise requires —

"appropriate authority" in relation to a specified profession, means —

(a) the Board established for that profession;

(b) where there is no such Board, the Minister;

"Bermuda Medical Board" means the Bermuda Medical Board constituted under the Medical Practitioners Act 1950;

"Board" means a Board established under section 4;

"Council" means the Council for the Professions Supplementary to Medicine established under section 3;

"medical practitioner" means a person entitled to practise in Bermuda as a medical practitioner under the Medical Practitioners Act 1950;

"Minister" means the Minister of Health and Social Services;

"prescribed" means prescribed by regulations;

"registered" means registered under section 5;

"regulations" means regulations prescribed under section 14;

"rules" means rules prescribed under section 14;

"specified profession" means any profession specified in the First Schedule.

(2) Where the Minister is the appropriate authority he shall, so far as is practicable, discharge his functions under this Act in consultation with practitioners of the specified profession concerned, but no court shall inquire whether or not there has been such consultation.

Act not to apply in relation to certain armed forces.

2. Nothing in this Act shall apply to the practice of a specified profession by a person who is an officer or employee of any of the naval, military or air forces of Her Majesty or of the United States of America –

(a) on or in relation to a person who is a member of such a force or the family of such a member; or

(b) on or in relation to a person who is employed directly by such a force.

Council.

3. (1) There shall be established for all the specified professions a body of persons, to be called the Council for the Professions Supplementary to Medicine, which shall have the general function of co-ordinating the activities of the Boards and specified professions, determining their relationship with the medical profession and other related professions and advising the Minister in respect thereto.

(2) The Council shall consist of –

(a) a Chairman appointed by the Minister;

(b) one member who shall be a medical practitioner appointed by the Minister after consultation with the Bermuda Medical Board;

(c) one member elected by each Board, who shall be a practitioner of the specified profession for which the Board is established;

(d) one member appointed by the Minister for each of the specified professions for which there is not a Board, who shall be a registered practitioner of that profession.

(3) The incidental provisions contained in the Second Schedule shall have effect with respect to the Council.

Boards.

4. (1) Where there are five or more persons lawfully practising a specified profession in Bermuda there shall be established for that profession a Board, which shall exercise and perform the functions assigned to it under this Act.

(2) Each Board shall consist of –

(a) a Chairman appointed by the Minister;

(b) if the Chairman is not a medical practitioner, a member who is such a practitioner appointed by the Minister;

(c) three members elected from among themselves by registered persons practising the profession for which the Board is established.

(3) When a Board has been established under the provisions of this section it shall continue in being notwithstanding that there are less than five persons in Bermuda lawfully practising the specified profession for which it has been established until such time as it is abolished by the Minister by order published in the Gazette.

(4) The incidental provisions contained in the Second Schedule shall have effect with respect to each Board.

PART II
REGISTRATION AND DISCIPLINE

Establishment and maintenance of registers.

5. (1) No person shall practise a specified profession in Bermuda unless his name appears on the register maintained by the Minister in respect of that profession for the purposes of this Act.

(2) A person seeking to be registered shall make application therefor in the prescribed manner to the Minister.

(3) Subject to section 7 and the regulations a person shall be registered if he satisfies the appropriate authority –

(a) that he holds a qualification for the time being accepted for the purposes of this Act by the appropriate authority; and

(b) if the appropriate authority so requires, that he has had sufficient practical experience in his profession,

and he is otherwise, in the opinion of the appropriate authority, a fit and proper person to be registered.

(4) The Minister shall register a person carrying on a specified profession in Bermuda at the commencement of this Act notwithstanding that he does not hold a qualification of the nature specified in subsection (3)(a) if the appropriate authority is of the opinion that such person is competent to practise such profession.

(5) In determining whether a person is a fit and proper person to be registered in accordance with the provisions of subsections (3) and (4) the appropriate authority may require that person to undergo such tests or examinations as it may consider appropriate.

(6) Notice of the acceptance of a qualification for the purposes of subsection (3) shall be published in the Gazette.

Proof of registration.

6. A certificate purporting to be under the hand of the Permanent Secretary, Ministry of Health and Social Services declaring that a person named therein is, or is not, as the case may be, registered in any register maintained under this Act, and in the case of a person who is so registered specifying the date of registration, shall be admissible in any proceedings as *prima facie* evidence of the facts stated therein.

Removal of names from register for crime, infamous conduct, incapacity etc.

7. (1) Where –

(a) a person whose name appears on a register is convicted by any court in Bermuda or elsewhere of a criminal offence which, in the opinion of the appropriate authority, renders him unfit to be registered; or

(b) such a person is, in the opinion of the appropriate authority, guilty of infamous conduct in any professional respect; or

(c) the appropriate authority is satisfied that the name of such a person has been fraudulently entered on the register maintained by it; or

(d) the appropriate authority is satisfied that such a person is, by reason of mental disorder or incapacity, incapable of carrying on his profession,

the appropriate authority may, if it thinks fit, direct that the person's name shall be removed from the register.

(2) A direction shall not be given under subsection (1) save after an inquiry in accordance with the regulations.

(3) Any person aggrieved by a direction of the appropriate authority under subsection (1) may, at any time within twenty-eight days from the date of receiving notice of the direction, appeal against the direction to the Supreme Court in accordance with the rules.

(4) A direction for the removal of a name from the register shall take effect —

(a) where no appeal under this section is brought against the direction within the time limited for the appeal, on the expiration of that time;

(b) where such an appeal is brought and is withdrawn or struck out for want of prosecution, on the withdrawal or striking out of the appeal;

(c) where such an appeal is brought and is not withdrawn or struck out as aforesaid, if and when the appeal is dismissed.

Registration after removal of name from register.

8. A person whose name is removed from a register in pursuance of a direction of the appropriate authority under section 7 shall not be entitled to be registered in that register again except in pursuance of a direction in that behalf given by the appropriate authority on the application of that person; and a direction under section 7 for the removal of a person's name from the register may prohibit an application under this section by that person until the expiration of such period from the date of the direction as may be specified in the direction.

Power of appropriate authority to obtain information.

9. (1) For the purpose of an inquiry under section 7(2) the appropriate authority shall have power by order under the hand of —

(a) the Chairman of the Board, where the appropriate authority is a Board;

(b) the Minister, where he is the appropriate authority,

to require any person to attend before the appropriate authority and to give evidence on oath or otherwise, and to require the production of documents, so as to elicit all such information as the appropriate authority may consider necessary.

(2) Any person who —

(a) fails without reasonable excuse to attend before the appropriate authority in compliance with an order under subsection (1);

(b) when in attendance before the appropriate authority refuses to make an oath, or refuses to produce a document, or refuses to give evidence, in compliance with such an order as aforesaid,

shall be guilty of an offence and shall be liable on summary conviction therefor to a fine not exceeding two hundred and fifty dollars:

Provided that the person shall not be punished for refusing to answer any question or to produce any document which he could not be required to answer or produce before a court of Bermuda, or for failing or refusing to answer any question or produce any document which is not relevant to the matters in issue.

Statement as to proper or improper conduct

10. (1) It shall be the duty of the appropriate authority to prepare, and from time to time revise, in consultation with the Council, a statement as to the kind of conduct which the appropriate authority considers to be proper or improper conduct in a professional respect, and the appropriate authority shall send by post to each registered member of a specified profession at his address on the register, a copy of the statement as for the time being revised.

(2) In the exercise of its functions under section 7 the appropriate authority shall be guided by any relevant statement prepared under this section but it may hold a person guilty of infamous conduct in a professional respect notwithstanding that such conduct is not prohibited by the statement; but the appropriate authority shall not hold a person guilty of infamous conduct in a professional respect if such conduct is authorised by the statement.

PART III
OFFENCES AND SUPPLEMENTARY

Use of titles.

11. (1) A person who is registered shall be entitled to use the word "registered" to describe the nature of his professional practice, where that practice is the practice in respect of which he is registered.

(2) Any person –

(a) who uses, either alone or in conjunction with other words, the words "Government Registered", or words of like purport to describe the nature of his practice, being that of a specified profession, and is not registered in respect of that profession; or

(b) who takes or uses any name, title, addition or description falsely implying, or who otherwise pretends,

that his name is on a register established under this Act,

shall be guilty of an offence and shall be liable on summary conviction therefor to a fine not exceeding two hundred and fifty dollars and, in the case of a second or subsequent conviction, to a fine not exceeding five hundred dollars.

Penalty for false representations, etc., to obtain registration.

12. If a person procures or attempts to procure the entry of any name on a register established under this Act by wilfully making or producing, or causing to be made or produced, either verbally or in writing, any declaration, certificate or representation which he knows to be false shall be guilty of an offence and shall be liable on summary conviction therefor to a fine not exceeding five hundred dollars.

Unlawful practice.

13. (1) No person shall practise a specified profession (by whatever name called) unless —

(a) he is registered in respect of that profession; or

(b) his practice is incidental to the practice of some other profession lawfully carried on by him in accordance with the laws regulating the practice of that other profession.

(2) Any person who contravenes the provisions of this section shall be guilty of an offence and shall be liable on summary conviction therefor to a fine not exceeding two hundred and fifty dollars and, in the case of a second or subsequent conviction, to a fine not exceeding five hundred dollars.

Regulations and rules.

14. (1) The Minister may make regulations for the better administration of this Act and, without derogation from the generality of the foregoing, such regulations may —

(a) prescribe anything which, under this Act, is required or permitted to be prescribed;

(b) prescribe fees payable by an applicant for registration under this Act or in connection with any examination or test required to be undertaken by such an applicant;

(c) prescribe the procedure to be followed by the appropriate authority;

(d) prescribe the manner in which any notice required by the Act or regulations to be served on any person shall be served;

(e) regulate the making of applications for registration and provide for the evidence to be produced in support of an application.

(2) The power of the Chief Justice to make rules under section 21 of the Supreme Court Act 1905 shall extend to the making of rules regulating the practice and procedure to be followed on an appeal to the Supreme Court under section 7(3), and the fees payable in connection therewith.

(3) Regulations under this section shall be published in the Gazette.

Amendment of First Schedule.

15. (1) The Minister may, after consultation with the Council, amend the First Schedule by –

(a) varying the definition or style of any profession; or

(b) adding any profession thereto or removing any profession therefrom.

(2) An order under this section shall be laid before both Houses of the Legislature as soon as practicable after it has been made; and if either House within three days after a copy of the order has been laid before it, being days on which the House has sat resolves that the order or any part be annulled, then such order, or such part, as the case may be, shall be deemed to have been revoked with effect from the date of such resolution.

Consequential amendments.

16. (1) The Medical Practitioners Act 1950 shall be amended in section 2(1) by the insertion after the word "midwife" in the proviso thereto of the words "or in relation to the practice of his profession by any person registered under the Professions Supplementary to Medicine Act 1973".

(2) The Government Authorities (Fees) Act 1971 shall be amended in Part III of the First Schedule by the addition under the heading "Authority" of the following item –

"The Council and Boards for the professions supplementary to medicine established under sections 3 and 4 of the Professions Supplementary to Medicine Act 1973".

Transitional.

17. (1) Nothing in this Act shall prevent a person who was practising a specified profession in Bermuda at the commencement of this Act from continuing to practise such profession for a period of six months after such commencement.

(2) During the period specified in subsection (1) any person carrying on the practice of a specified profession by virtue of the provisions of that subsection shall be deemed to be registered for the purposes of this Act.

Commencement.

18. This Act shall come into operation on such day as the Minister may, by notice in the Gazette, appoint.

FIRST SCHEDULE

"chiropodist" means a person skilled in the treatment of foot conditions locally and conservatively and the palliative relief of chronic foot anomalies and resultant lesions;

"dietician" means a person skilled in the science of relating diet or food to health and disease and the systematic regulation of such diet;

"medical laboratory technician" means a person skilled in medical laboratory techniques;

"occupational therapist" means a person skilled in the treatment of disability, illness or injury using different forms of activity, work or recreation;

"physiotherapist" means a person skilled in the stimulation of healing and the return of function by the use of physical means, in the rehabilitation of the sick and injured;

"radiographer" means a person skilled in the use of X-ray radiation as a means of diagnosis and therapy;

"speech therapist" means a person skilled in the treatment of disorders of speech, voice, language and communication.

SECOND SCHEDULE

PART I

Provisions Common to the Council and the Boards

1. A member of the Council or a Board shall be appointed or elected, as the case may be, for a period of one year beginning on such day as may be determined by the Minister.

2. A member of the Council or a Board may resign his office at any time by notice in writing given to the Minister.

3. The Minister may declare the office of a member of the Council or a Board vacant if he is satisfied that the member –

   (a) is unable through mental or physical incapacity or absence from Bermuda to perform the functions of his office;

   (b) has failed, without adequate cause, to attend three successive meetings of the Council or Board;

   (c) has been sentenced to imprisonment for the commission of a criminal offence;

   (d) has had his name removed from the register under section 7.

4. (1) A person appointed or elected to fill the place of a member of the Council or a Board before the end of the member's term of office shall hold office so long only as the vacating member would have held office.

(2) Where the place of a member of the Council or of a Board becomes vacant before the end of his term of office and the unexpired portion of his term of office is less than three months, the vacancy need not be filled.

5. A person who has held office as a member of the Council or a Board shall be eligible for re-appointment or re-election, as the case may be.

6. The Council or a Board may act notwithstanding any vacancy in its membership, and no act of the Council or a Board shall be deemed to be invalid only by reason of a defect in the appointment or election of a member thereof.

7. Subject to the foregoing provisions of this Schedule, the Council and a Board may determine its quorum and procedure.

PART II

Special Provisions Relating to the Council

1. There shall be not less than two Council meetings in each calendar year.

PART III

Special Provisions Relating to the Boards

1. Boards shall meet as often as may be necessary for them to dispatch their business under this Act.

2. A minute shall be made of every decision of a Board in such form as the Minister may direct.

3. (1) Where any matter is before a Board under section 5 or 7, a member of the Board may, with the leave of the Chairman, withdraw on the ground that he is personally acquainted with the facts of the case or for any other reason which the Chairman deems sufficient and the Chairman may himself withdraw on any such ground.

(2) Where a member has so withdrawn, the Chairman may request the Minister to appoint some person, who need not be a practitioner of a specified profession, to be a member of the

Board for the purpose of those proceedings, and the Minister may, if he thinks fit, make such an appointment, whereupon the person so appointed shall be deemed to be a member of the Board for such purpose.

4. The election of members to a Board shall be conducted in such manner as the Minister may approve and any dispute as to who is, or who is not, entitled to vote at such an election shall be determined by the Minister.

5. In any matter before a Board the Chairman or person acting as Chairman shall have a deliberative as well as a casting vote.

For the purposes of this Schedule a reference to a member or the membership of the Council or a Board shall, unless the context requires otherwise, be construed as including the Chairman.

About the Authors

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Professor N. R. E. Fendall, B.Sc, MD, DPH, FFCM, qualified from University College, London in 1942. After the usual house jobs entered Her Majesty's Overseas Medical Services and was posted to Yaba School of Medicine, Nigeria. During the war he served in the Far East and reassumed his civilian career in Malaya in the immediate post-war period. In 1948 he transferred to Kenya where he remained for the rest of his colonial career, ending it as Director of Medical Services of Kenya.

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