TRADITIONAL AND ALTERNATIVE SYSTEMS OF MEDICINE:
A COMPARATIVE REVIEW OF LEGISLATION

by

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International Digest of Health Legislation, 1985, 36 (2)
1. INTRODUCTION

Since the advances in modern scientific medicine began, the legal regulation of health care has been developing according to a similar, if not uniform, pattern which first emerged in continental Europe. Legislation was designed to regulate the delivery of health care as a monopoly of formally educated physicians and a few other professions. Subsequently, the practice of even the allied and auxiliary health professions was limited to licensed persons. North and South America followed the European example in organizing health care on the basis of the monopoly of these professions. As nearly all the rest of the world, with the exception of China and Japan, was under the colonial domination of a few European countries, the concept of health care regulated by law as a monopoly or prerogative of licensed professions was introduced by colonial legislation throughout what are now termed the developing countries. The type of health care so provided was based exclusively on modern scientific medicine. Thus in rural Africa or the forests of South America, just as in Paris or Los Angeles, it has been against the law throughout this century for persons other than university-trained physicians to practise medicine; it goes without saying, however, that the enforcement of the law varied considerably in different countries.

The rationale underlying such laws was partly concern for the health of the population, perceived as requiring protection against quacks, unqualified healers, and charlatans, and partly a genuine belief of the medical profession that every attempt at healing outside the framework of recognized medicine was harmful, or at best, ineffectual. Such concerns were combined with the hope that the technical progress of mankind would in the not too distant future make it possible for qualified health care to be delivered to all in need of it. There was, in addition, a strong secondary motive underlying monopolistic or preferential legislation, namely protectionism in favour of those already established in their occupations. Proposals to liberalize some fields of health care met (and sometimes still meet) with resistance from organized professions enjoying monopolistic positions under the existing laws.

As the same time, however, people of most nations and of various cultures always relied on various forms of what has come to be called traditional medicine, a term extending from applications of herbal medicine to faith-healing and other practices based on the supernatural. In advanced societies these forms of healing may exist in conjunction with the system of scientific health care; in most of the developing countries, where access to formal medical institutions is minimal or totally lacking, traditional medicine continues to be the main, and sometimes the only, form of health care for hundreds of millions of people, a situation which shows little sign of changing.

Excessive reliance on the formal "Western" or "modern" system has come to be recognized in the second half of this century as an inadequate solution to problems of health care delivery in the developing countries. Some governments have been obliged to recognize that an exclusive system of formalized medicine is both impracticable and indeed harmful to public health in those areas where existing health care resources are unable to meet even the most basic needs of primary health care. The legislatures of many of the countries that have recently become independent are thus faced with the task of removing legal barriers, of relaxing the prohibitions against practitioners of indigenous traditional medicine, and of incorporating these practitioners in a looser and more flexible system of health care delivery.

In the 1970s interest in the use of practitioners of traditional medicine in primary health care was growing. Since 1974, traditional medicine has been incorporated in relevant WHO programmes and in October 1976 representatives of WHO's regional offices met in New Delhi and proposed certain programme objectives. The suggested approaches included the formulation of national health policies that would contain provisions concerning traditional medicine and medicines for the coordination and better utilization of the useful elements of traditional medicine in countries' health care systems. In May 1977 the World Health Assembly urged "interested governments to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations as suited to their national health systems". In 1978 the World Health Assembly urged "interested governments to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations as suited to their national health systems". In 1978 the World Health Assembly urged "interested governments to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations as suited to their national health systems". In 1978 the World Health Assembly urged "interested governments to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations as suited to their national health systems". In 1978 the World Health Assembly urged "interested governments to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations as suited to their national health systems". In 1978 the World Health Assembly urged "interested governments to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations as suited to their national health systems". In 1978 the World Health Assembly urged "interested governments to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations as suited to their national health systems". In 1978 the World Health Assembly urged "interested governments to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations as suited to their national health systems".

In the developing countries, and indeed in other countries albeit to a lesser degree, there is now support for liberalizing the position to permit traditional medicine to operate in conjunction with its modern counterpart.

Looking at the current legal trend in its broadest outlines, it may be affirmed that most of the countries in South and East Asia have introduced more or less substantial changes in their health laws for the purpose of either tolerating or recognizing some systems of traditional health care. In the independent States of most of the African continent, the colonial concept of health care systems based on professional physicians, pharmacists, and dentists still persists as the basic element but the policies of some governments have begun to recognize the need for change. In the Sub-Saharan region an additional political aspect of the problem is emerging, namely policies emphasizing that the indigenous forms of traditional medicine are part of older national cultures that should be revived. Such policies, however, are not always...
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A WHO Meeting on the Promotion and Development of Traditional Medicine, held in Geneva in 1977, proposed a policy of integration of traditional medicine into primary health care. The meeting suggested, among other guidelines for such policy, that traditional practitioners be “retrained” for appropriate use in primary health care, and that professional health personnel and students of modern systems be acquainted with the principles of traditional medicine in order to facilitate integration. The 1978 Declaration of Alma-Ata referred to the need for a variety of health workers, including traditional practitioners. In 1983 WHO published a collection of 29 essays as a reader in order to provide guidance for health administrators and practitioners.

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followed by legislative enactments. A certain lack of legislative reaction to the issue of traditional medicine can also be discerned in most countries of South and Central America. Except for occasional provisions dealing with medicinal plants or traditional birth attendants, little has been done to regularize traditional medicine even in the vast rural areas of the continent. In various developed countries, legislation permits and regulates the practice of some specific non-orthodox approaches to health care, such as chiropractic and osteopathy, and most recently acupuncture has come under legal regulation. On the other hand, in the socialist countries of Eastern Europe, where the health professions have as a rule become integrated into the public services, health care is provided virtually exclusively on the basis of modern medicine.

This review attempts to describe the various forms and patterns of law now in force in the developing and to some extent also in the developed countries insofar as they affirmatively or negatively regulate or directly affect the practice of traditional (or alternative) medicine in various regions and countries of the world. In view of the variety of the legislation, sometimes accessible only with difficulty, and on account of the lack of substantial legal research in this field, such an attempt must naturally be modest in scope. Its purpose is to list a number of possible legislative approaches and solutions to the various problems involved in regulating traditional medicine.

For the purposes of this review, the term "traditional medicine" is interpreted in a broad sense. It includes, inter alia: (1) formalized traditional systems of medicine, such as Ayurveda, Unani, and Chinese traditional medicine; (2) the practices of traditional healers as defined by an expert group in WHO's African region in 1976 in the following terms: "... a person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability"; and (3) practices of alternative medicine such as chiropractic, osteopathy, naturopathy, and homoeopathy.

The relevant legislation employs a great variety of terms to delimit the entire area or various fields of traditional medicine. Thus, in Thailand for example, the Drugs Act 1967 distinguishes "old-style medicine" and "modern medicine". In Sri Lanka the Homoeopathy Act, No. 7 of 1970 defines homoeopathy as the system of medicine established by Dr Hahnemann. Where legislation or court decisions deal with unorthodox healing occupations, most often in the United States of America or in some Commonwealth countries, various legal definitions attempt to delimit such activities as chiropractic ("a system of therapeutic treatment for various diseases, through the adjusting of articulations of the human body, particularly those of the spine, with the object of relieving pressure or tension on nerve filaments"); "science of palpating and adjusting the articulation of the spinal column by the

2. THE POSITION OF TRADITIONAL MEDICINE IN HEALTH CARE SYSTEMS

In order to present the various legislative approaches to traditional medicine, the following broad categories of policies for the legal regulation of health care in individual countries will be examined:

- The exclusive (monopolistic) systems, where only the practice of modern, scientific medicine by professionals and auxiliaries is recognized as lawful, with the exclusion of and sanctions against all other forms of healing. The actual enforcement of such stringent legislation varies from one country to another.

- The tolerant systems, where only the system based on modern medicine is recognized, although, at least to some extent, the practitioners of various forms of traditional medicine are tolerated by law.

- The inclusive systems, in which systems other than modern medicine are not merely tolerated, but are recognized as forming a special part of the structure of health care.

- The integrated systems, in which there is official promotion of the integration of two or more systems within a single recognized service; integrated training of health practitioners is the official policy.

The above categorization can of course serve only for a very approximate grouping of various countries' policies and legal regulation concerning traditional medicine.8

The exclusive (monopolistic) systems

During the 19th and the first half of the 20th centuries, the health laws of most of the countries of the European continent and of the Americas (as well as those of many of the then colonies) were formulated as diverse modifications of the monopolistic system under which health care was dispensed by university-trained physicians and a few other professions with formal training, such as dentists, pharmacists, and nurses. Several patterns can be distinguished within this system.

There may be a strict, total, and enforced monopoly, as in France or Belgium. Under French law (Articles L. 356, L. 372, and L. 376 of the

8 Indeed Leslie has suggested that it is appropriate "... to clarify our typology for describing the legal role of traditional medicine in different medical systems by showing that: (1) they are all dominated by modern or monopolistic medicine, (2) in practice [emphasis added] the exclusive systems are pluralistic, and (3) the integrated systems exclude many aspects of traditional medicine. Furthermore, and more, in practice the inclusive and integrated systems form a continuum, just as the exclusive and tolerant systems are continuous with each other. The primary contrast in our typology is therefore between these two sets of normative systems."
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Public Health Code), any person other than a licensed physician who habitually or continuously diagnoses or treats illnesses, real or surmised, or who performs activities constituting "medical procedures", commits the offence of the illegal practice of medicine. Numerous court decisions, delivered over several decades, indicate the stringency with which these restrictive provisions have been enforced. Furthermore, these provisions have been forcibly interpreted. The French courts have constantly held that it is not only the provision of "scientific treatment" which may give rise to the offence of the illegal practice of medicine; even in the 20th century the courts have ruled that the following constitute punishable offences: chiropractic, hypnosis, acts of "magnetism" or "spiritualism", psychoanalysis, sorcery, imposition of hands, treatment of baldness by a pharmacist, and indeed advice as to the positioning of a bed. Supernatural and religious healing practices have been tolerated by the courts, but it has been held that such acts lose their religious character and become "curative" when they include a physical procedure carried out on the person treated, or the prescription of drugs. Several Orders have been issued since 1962 establishing and extending lists of "medical procedures" which may be performed only by physicians or by members of specific allied health professions.

In Belgium, Luxembourg, and Italy a professional monopoly of the diagnosis, treatment, and prevention of disease is likewise enforced, in the framework of legal systems somewhat similar to that of France. The enforcement of such laws is reported to be strict in Belgium.

In the Netherlands the medical professions enjoy a complete monopoly under the Law of 1 June 1865 on the practice of medicine but enforcement of the law is only intermittent. ("In spite of the absolute and complete prohibition, unlawful practice of medicine is frequent... in practice nearly everything is tolerated", states a report cited below). A bill on professional practice in the field of medicine has been drafted recently. Legal aspects of the present situation and issues of the law reform in preparation are dealt with in the report of an advisory commission established by the Government to make recommendations on law reform. During the first half of the 20th century, similarly restrictive legislation spread to most of the French and Belgian colonies in Africa where it remained in force, although not implemented in practice, even after those countries attained their independence.

All the States of the USA have legislation prescribing that any person practising medicine or surgery must possess a licence or a certificate of qualification.

Austrian law provides a narrower, less universal, definition of medical acts. Under Section 1 (2) of the Federal Medical Law (as amended in 1964), the practice of medicine "includes all activities based on medico-scientific knowledge" (emphasis added) performed for the purposes of diagnosis, treatment, prophylaxis, etc.¹¹

H alf a century ago certain legal writers in France also advocated that limits should be imposed on physicians' monopoly of healing activities based on scientific medicine. Although these views were in fact upheld in certain decisions of the lower courts, ultimately they were not authoritatively incorporated into the legal system.¹³

The main characteristic of the system of health care in the USSR and in the East European socialist countries is the exclusiveness of health care provided by the State. Except for a few remnants of private practice, health care in these countries has become a public service. The Fundamental Principles of the Health Legislation of the USSR and of the Union Republics of 19 September 1969 declare that the population is to be provided with "free, qualified medical care, provided by State health institutions and accessible to everyone" (Section 4); the practice of medical and pharmaceutical activities is limited to persons who have undergone appropriate training in medical or pharmaceutical educational establishments, and the practice of such activities by unauthorized persons is unlawful and punishable (Section 12); physicians are required to use diagnostic, prophylactic, and therapeutic methods and the pharmaceutical products authorized by the USSR Ministry of Health (Section 34).

In their efforts to meet the needs of the entire population through an organized network of medical establishments, the socialist countries continue to employ systems based on the exclusivity of modern scientific medicine. Traditional medicine is in no way regarded as a valuable heritage of a national culture.

... Even the injunction to reexamine the clinical merits of [folk medicine and folk remedies] was usually coupled with the admonition to separate what was scientifically valid from what was useless.

The development of a parallel system was never encouraged... charlatans, quacks, faith healers, and native practitioners... are stigmatized in official publications as the last remnants of superstition and ignorance to be rooted out by an enlightened and scientific approach.¹⁵

The Czech Methodological Directives No. 2 of 1980 on the procedure for performing acupuncture¹⁸ illustrate the characteristic outlook of the East European health care systems. Acupuncture may be carried out only by physicians who hold specialist qualifications in any of the clinical branches and who have undergone special further training; it is to be carried out in specialized health establishments with appropriate staff and equipment.

A guarded, if not negative, attitude towards at least certain branches of traditional medicine can also be discerned in some of those developing countries that have adopted socialist systems.

Thus, the Algerian Public Health Code of 23 October 1976,¹⁷ in part still influenced by the French model, introduced a monopoly in favour of the licensed medical professions and rendered the illegal exercise of medicine an offence. Apart from Section 362 (Practice of the profession of herbalist), no exception was made in favour of practitioners of...
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traditional medicine, and Section 47(3) expressly prohibited medical auxiliaries from resorting to "secret or occult procedures". This monopoly principle was retained in Law No. 85-05 of 16 February 1985 relating to health protection and promotion (which, *inter alia*, repealed the above-mentioned Code). For reasons that are not entirely clear, there are no provisions on herbalists in the new Law. Section 225 includes provisions prohibiting medical auxiliaries from "announcing or applying technical procedures other than those that are taught in national training programmes". It has been reported that traditional healers are prohibited from practising in Democratic Yemen, while in Mongolia Section 13 of the Health Law approved on 27 June 1977 specifically prohibits "the practice of medicine and pharmacy other than under the prescribed conditions". However, the foregoing does not seem to be the case in the Democratic People's Republic of Korea, where some influence of the old tradition can be observed (see p. 314).

As has already been mentioned, prior to the Second World War Western European laws, generally based on a monopoly of modern scientific medicine administered by licensed professionals, were introduced by the colonial States into their subject territories. Similar legislation was adopted in most of the Latin American countries. The usual legislative pattern was that the law authorized the practice of medicine, midwifery, dentistry, or pharmacy only by persons who had been duly trained in appropriate establishments and who were registered. This implied prohibition on healing activities by persons who were not members of the established medical professions. Such prohibitions were sometimes expressly formulated and penal sanctions prescribed for offences. Sometimes the prohibitions were specific in nature, such as those prohibiting some forms of healing by supernatural forces (see the section on witchcraft, p. 331); alternatively, the prohibition might be formulated in broader terms, as in the case in the Honduran Health Code: Section 130 of the Code reads as follows:

*The practice of naturopathy [naturalistas], homoeopathy, empiricism, and other occupations considered to be harmful or useless by the Secretariat for Public Health and Social Welfare shall be prohibited in the country.*

Even in the 1970s, some laws organizing health care are based on the principle of the monopoly of formally educated medical professions, thus making the practice of traditional medicine illegal. Thus, Section 13 of the Venezuelan Law on the practice of medicine provides that persons who, without fulfilling the requirements of this Law, perform any act that is restricted to medical practitioners, "are deemed to practise medicine illegally". (Only traditional birth attendants who have received a ministerial permit are exempted).

Some data may serve to provide an outline of the situation on which this monopoly system was imposed. It is generally accepted that between two-thirds and three-quarters of the indigenous population in Africa and Central and South America have no access to health care other than that supplied by practitioners of traditional medicine. The
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Some data may serve to provide an outline of the situation on which this monopoly system was imposed. It is generally accepted that between two-thirds and three-quarters of the indigenous population in Africa and Central and South America have no access to health care other than that supplied by practitioners of traditional medicine. The situation in Nigeria and Ghana, where extensive research has been done, may well be typical. A few years ago, it was estimated that in the Northern Region of Nigeria there was one physician for every 100,000 inhabitants (the ratio was 1:2000 in Lagos). A similar ratio, 1:100,000, was given for the Upper Ghana region in the early 1970s, i.e. eight physicians for nearly 900,000 people. It has been stated that in the period 1975-1980 only 3% of the total budget of Ghana was allocated to health and that of that fraction only 15% was allocated to primary health care, which was supposed to meet the needs of some nine million people.

It is self-evident that in regions where the expensive and complicated structure of modern scientific medicine is unable to satisfy even the most basic needs of a small fraction of the population, and where people have always resorted to indigenous forms of healing, it is entirely unrealistic to prohibit traditional medicine. The law is powerless to interfere with the daily practices of all sorts of traditional healers. Unless "something goes wrong", mostly where a conspicuous death results from evident malpractice, such healers are unmolested and informally tolerated, although they are denied official recognition. This is true even in cities, although perhaps to a lesser degree than in rural areas. There is, then, a considerable discrepancy between the letter of the law and its enforcement in practice. The governments of such developing countries accept this situation, and thus de facto toleration of indigenous systems of healing is still usual in most countries of the Middle East, of both North and Sub-Saharan Africa, and in South and Central America. Only in recent years have legislative changes appeared in some African and other countries. The effect of prohibitive legislation is minimal or nonexistent. This may be one of the reasons why, for several years after becoming independent, many developing countries did not undertake reforms, establishing legislation supportive of traditional medicine. (Another reason may be the resistance of many of the indigenous professionals, who were trained and grew up in modern medicine, inheriting the traditional mistrust of any alternative systems of health care). It was not until the 1970s that some governments adopted policies intended to liberalize the system and legalize the practice of traditional medicine.

The de facto toleration of traditional healers, despite the absolute monopoly of formalized professions, is not limited to developing countries. As has been stated above, a strict monopoly for the medical professions exists in virtually all the States of the USA. However, many members of racial minorities turn for health care to traditional practitioners of their own cultures, a situation which seems to be considered natural by the general public as well as by the authorities.

The tolerant systems

In contrast to the "exclusive" systems described above, some of those developed countries with particularly advanced health care
systems do not prohibit healing by persons who have not received formal training or who employ non-scientific methods. This is the case in the Federal Republic of Germany, the United Kingdom, and the Scandinavian countries. In these countries medical care is naturally based on scientific medicine and provided by professionals with formal training and qualifications. This is best demonstrated by the fact that only registered professionals are included in the National Health Service in the United Kingdom, or may provide treatment under the health insurance systems in the Federal Republic of Germany. (Although the laws of those countries do not exclude non-physicians from providing non-orthodox health care, formally trained practitioners do enjoy a monopoly in the field of dentistry).

A category unique in Europe, that of licensed lay health practitioners, developed in Germany. Until the Second World War there existed a "freedom to treat" [Kurierfreihheit] that was limited neither by a monopoly enjoyed by formally educated physicians or to treatment according to the generally recognized lex artis of the established medical sciences. Anyone could practise healing without a licence or official authorization. Although a non-physician was obliged to recommend medical treatment in a situation where life might be endangered, he could legally treat patients with methods in which he sincerely believed. In a well-known case in the 1930s, the Reich Supreme Court [Reichsgericht] acquitted a healer who was "of low intelligence" and self-taught in homoeopathy. The healer employed homoeopathic methods to treat a child suffering from diphtheria, who subsequently died. In 1939 a Law was promulgated regulating the occupation of "lay health practitioners" [Heilpraktiker]. Under the provisions of this Law, as amended in 1974, anyone above the age of 25 who has been licensed by the competent administrative agency may practise. No special knowledge is required, and applicants do not have to pass a full-scale examination; a test is carried out by the health authorities but it is merely intended to establish that a lay practitioner does not represent a "danger to the health of the population". The test does not examine basic knowledge of medicine but only that the lay practitioner has sufficient knowledge of the law concerning communicable diseases, the duty to notify cases of such diseases, and the like. Any person who passes the test is entitled to a licence. Licensed lay health practitioners thus enjoy a general right to provide treatment, although that right is restricted by specific legislation excluding them from certain fields such as obstetrics and gynaecology, dentistry, and the treatment of communicable and venereal diseases, and prohibiting the prescription of certain drugs. As the Federal High Court [Bundesgerichtshof] held, the general prohibition on commercial advertising applicable to physicians does not extend to lay health practitioners (although advertising amounting to unfair competition is not permitted). Treatment provided by such practitioners is not covered by the health insurance systems.

The 1939 Law regulating the occupation of lay health practitioners remains in force in the German Democratic Republic. Nevertheless, as the GDR looks with disfavour upon health practitioners other than those integrated into the institutionalized system of scientific medicine, no licences have been issued since 1949. Those lay practitioners who still practise do so on the basis of licences issued before that date. According to an estimate of the Institute of Drug Affairs, only 50 or so practitioners, all elderly, remained in practice in the GDR at the end of the 1970s. In the Federal Republic, on the other hand, lay practitioners continue to be a "ubiquitous phenomenon"; various schools have been established to train and prepare them for the test referred to above.

Thus in the Federal Republic of Germany (and to a certain though diminishing extent in the German Democratic Republic) two categories of health professionals exist; both are authorized to administer health care, while other persons may not practise healing. The reasons for the enactment of the Law on lay practitioners can be traced, to some extent, to traditions of lay healing surviving from pre-1914 Germany. It should, however, be noted that the intention of the legislature, when the 1939 Law was enacted, was to run down the profession and ultimately to eliminate it. Subsection 1 of Section 2 provided that persons who had not been in practice before 1939 were to be granted licences only exceptionally and on special grounds. Such a limitation, however, was declared unconstitutional in the Federal Republic by the Federal Constitutional Court [Bundesverfassungsgericht] after the 1949 Basic Law entered into force. Thereafter, the authorities were obliged to issue licences to all applicants who satisfied the requirements of the Law, viz., completing their elementary schooling and passing the test mentioned above.

One authority has summed up the present situation in the Federal Republic as follows:

The result is that, in this scientific world, in a field as important as human health, it is possible for persons to practise without establishing that they have undergone any training; the sole requirement is that their knowledge should attain a standard (scarcely an elevated level) sufficient to withstand an attempt by the Health Office to prove that they constitute a danger to the health of the public, an attempt which is rarely successful..."  

On 12 October 1983, the General Assembly of the Federal Health Council voted in favour of the repeal of the Kurierfreihheit of lay practitioners. It was pointed out that, under the law at present, no training in health at all is required, so that anyone may acquire a licence to provide health care subject only to a few limitations.

Practising medicine without either a medical qualification or a lay practitioner's licence is illegal in the Federal Republic. In 1984 an appeal court held that a psychologist with a university degree may not practise psychotherapy without first obtaining a licence as a lay practitioner. In the United Kingdom there is no monopoly in favour of either of licensed physicians or of modern medicine. What is protected by law is the status of registered physicians, i.e. the title of "registered medical practitioners". Under the Medical Act 1983, persons who have fulfilled
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International Digest of Health Legislation, 1985, 36 (2)
ed the statutory requirements as to qualifications are entitled to be registered as fully registered medical practitioners. Possession of a formal medical qualification is one of the requirements for registration. Registered practitioners enjoy exclusive rights, such as: to recover in the courts fees for treatment and advice; to be employed by, and dispense treatment under, the National Health Service; to hold appointments in public hospitals and other public establishments; to issue such medical certificates as are required by law; to perform certain medical acts (for example abortion, treatment for reward of venereal diseases, and removal of tissues from cadavers); and to issue prescriptions in respect of certain drugs as provided for by the Medicines Act 1968.

Under Section 49 of the 1983 Act, an offence is committed by:

... any person who wilfully and falsely pretends to be or takes or uses the name or title of physician, doctor of medicine... surgeon, general practitioner... or any name, title, addition or description implying that he is registered...

Subject to these exceptions, it is lawful for anyone to practise any form of medicine. Thus, persons who so desire, such as those of Asian origin, may be treated by practitioners of Ayurvedic or Unani medicine. Homoeopathy is practised and homoeopathic treatment is provided by physicians in the National Health Service, a state of affairs which was confirmed by the Minister of Health in July 1979. There is a private Act referring to homoeopathy, the Faculty of Homoeopathy Act 1950. Osteopaths, chiropractors, and acupuncturists may practise in the private sector.

Somewhat surprisingly, on the other hand, registered dentists enjoy a monopoly in the United Kingdom. Under the Dentists Act 1984, the “practice of dentistry” is defined as the performance of any such operation and the giving of any such treatment, advice, or attendance as is usually performed by dentists. The practice of dentistry by a person who is not a registered dentist (or a registered medical practitioner) is an offence under Section 38 of the Dentists Act.

For recent polemics on the need for “alternative medicine” in the United Kingdom, see p. 295.

The right to practise medicine in the Scandinavian countries is similar in essence to that described for the United Kingdom. The principal features of that right are outlined below.

Formally educated physicians do not enjoy a general monopoly to practise medicine. As a rule, anyone may practise healing but it is an offence to pretend to be a physician. Surgery and certain other medical procedures may be performed only by physicians. Thus, in Sweden, Law No. 409 of 1960 prohibiting activities in the health and medical care fields in certain cases, as amended in 1982, lays down that a person who is not a physician may not for gain:

- examine or treat a child under eight years of age;
- issue written recommendations or instructions for the treatment of the person who has consulted him without personally examining him; or
- test or supply contact lenses.

Under Sections 7 and 9 of Law No. 409, non-physicians who by inappropriate healing damage a person’s health may be charged with the criminal offence of “charlatanism constituting a danger to health” [hälsofarligt kvacksalver]. Persons found guilty are liable, in addition to punishment under the criminal law, to be prohibited from working in the field of health care. A similar system exists in Denmark under the provisions of the Law on the practice of medicine. An approach to the regulation of health care similar to the United Kingdom and Scandinavian systems has been proposed in the Netherlands (see infra).

During the last two decades, both in the developed and developing countries, it became evident that there was a demand that forms of health care other than those provided by modern scientific medicine should be accorded greater freedom than hitherto.

In the developed countries, the idea is to allow persons greater freedom in choosing the sort of health care they want so that a movement towards more tolerant regulation is apparent in some countries. A bill has been drafted in the Netherlands to regulate “occupations providing individual health care”. The bill is intended to introduce a tolerant system, allowing anyone to provide health care, with certain activities being exclusively reserved for registered members of health professions. One of the basic concepts is that the right of a person to self-determination must be respected. A Commission on Alternative Medicine, appointed in 1977 by the Netherlands Ministry of Public Health and Environmental Hygiene, published a comprehensive report in 1981, as has been mentioned above (see p. 288), while a somewhat similar development has taken place in Belgium, with the establishment of an action committee “for the freedom of therapy”, concerned with individuals’ freedom of choice of health care.

In the United Kingdom, an unusual discussion took place in 1983. The Times published three major articles criticizing the state of the orthodox medical profession and explaining and supporting the concept of “alternative medicine”. The starting-point of the criticism was that orthodox medical professionals “disregard the personal factor in medicine”, while alternative healers maintain a “holistic approach”, looking at the completeness of a patient, physically and psychologically. There is, it was stated, an “extra dimension” to the art of healing which deserves to be more fully integrated into conventional health practice. With patients in the United Kingdom opting on an increased scale for treatment through alternative forms of medicine, such as acupuncture, herbalism, osteopathy, and homoeopathy, the British Medical

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Association’s Board of Science set up a working party to consider means of assessing the value of alternative therapy. In Israel, the Minister of Health has decided to set up a public committee to investigate ways of “regularizing” the use of acupuncture, natural healing, and other forms of non-conventional medicine. In 1974 the Australian Parliament set up a Committee of Inquiry into Chiropractic, Osteopathy, Homoeopathy and Naturopathy which published an extensive report in 1977, while in New Zealand, a commission to inquire into chiropractic appointed by the Minister of Health, published its report “Chiropractic in New Zealand” in 1979.

In the United States of America, the liberalizing approach has been established in State legislation regulating unconventional forms of medicine, such as acupuncture, and has in addition been upheld in judgements of the courts. The courts have founded their decisions in favour of a liberalizing approach on the “right to privacy” (i.e. to self-determination). Thus a Federal District Court in Texas held that the right to select a particular form of treatment came within the fundamental right to privacy. The Court ruled, inter alia:

Health care decisions... are, to an extraordinary degree, intrinsically personal. It is the individual making the decision, and no one else, who lives the pain and disease. It is the individual making the decision, and no one else, who must undergo or forego the treatment. And it is the individual making the decision, and no one else, who, if he or she survives, must live with the result of that decision.

Unschuld formulates the problem as follows: “To what extent may an administration impose a given therapeutic system on a population even though segments of this population prefer a different therapeutic system?”. In the developing countries interest in traditional medicine has been fuelled by the overall lack of primary health care, so that issues concerning the legalization of the practices of traditional healers have come to the fore. In the election campaign in Nigeria in 1979, all political parties pledged in their manifestos that traditional practices would be integrated as they have been in India and China. The Second Ordinary Congress of the Popular Revolutionary Movement in Zaire adopted a resolution in November 1977 encouraging research into the rehabilitation and recognition of traditional medicine as a complement to modern medicine and urged the establishment of a traditional medicine division within the Department of Health. In addition, issues arising from the legalization of practices of traditional medicine have been discussed by a number of authors.

In spite of proclamations by politicians urging the integration of modern and traditional medicine, only a few of the developing countries have taken the first modest steps towards the legalization of the latter, either in general, or in respect to specific branches. Some of the possible reasons for this tardiness, the general non-enforcement of restrictive laws in practice and the animosity of professional circles, have been mentioned above. It may seem surprising that traditional medicine has been omitted from the recent Charter for the Health Development of the African Region by the Year 2000. This document, adopted at the 29th session of the WHO Regional Committee for Africa in September 1979, though considering that the strategy for achieving the social target of health for all by the year 2000 will have to be modified and brought up to date, does not mention traditional medicine either directly or by implication.

The following are a few examples of legislation in countries where, in theory, the established structure of health care is still firmly based on the concepts and organizational patterns of modern scientific medicine.

Latin American legislation shows a broad range from the prohibition of traditional medicine in Peru and Guatemala (though not enforced in practice) to an attempt at general regulation in Paraguay. Under Sections 234 and 235 of the Health Code of Paraguay, the Ministry of Public Health and Social Welfare is required to promote, carry out, and license the training of certain traditional health workers [empiricos en salud] and to register, license, and inspect them annually in carrying out their activities in localities where this is considered necessary by the Ministry. In some Latin American States the trend towards relatively tolerant legislation and policies is limited to a few specific forms of traditional medicine, typically traditional birth attendants (see p. 315) or practitioners of herbal medicine. Herbalists’ shops may be run only with prior authorization and the sale of medicinal herbs is subject to fairly detailed regulation in Argentina and Uruguay. In Brazil, special provisions restrict the dispensing of medicinal plants to pharmacies and herbalists’ shops. On the other hand, in Bolivia, pharmacies are prohibited from advertising, possessing, or dispensing medicaments whose composition is secret or mysterious.

In those African countries that were influenced by French or Belgian legal traditions, liberalization of traditional medicine has been cautious, if not hesitant. In Mali, the first step in this direction took the form of establishing a National Institute for Research on the Traditional Pharmacopoeia and Traditional Medicine in 1973. Under regulations on the functioning of this Institute, certain practices of traditional medicine were legalized. A further innovative measure was the establishment, by an Order of the Minister of Public Health and Social Affairs of 16 May 1980, of a Scientific and Technical Committee to work in conjunction with the Institute. The Committee, whose functions are defined in relation to the overall health care needs of the country, has now drawn up a first draft of regulations on the practice of traditional medicine.

In Burkina Faso, traditional practitioners have likewise attained a degree of recognition. This is illustrated by Section 49 of Title IV (Traditional medicine) of the Public Health Code of 28 December 1970, which reads as follows:

The practice of traditional medicine by persons of known repute shall be provisionally tolerated [emphasis added]; such persons shall remain responsible, under civil and penal law, for the acts which they perform.
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civil and penal law, for the acts which they perform.
Subsequent items of legislation shall define the practice of this form of medicine and the status of persons engaged therein.

A medical and scientific commission appointed by the Minister responsible for Public Health shall conduct a study of the practice of traditional medicine and shall undertake investigations, notably in respect to traditional therapeutics, in order to identify the mode of action and posology of the drugs involved.

A special procedure has developed in Niger. A candidate for the licence to practice traditional medicine is assigned to the National Hospital in Niamey, where he practises for a certain time under the supervision of the Chief Physician. If the Chief Physician is satisfied, he recommends to the Ministry of Public Health and Social Affairs that the licence should be granted. 24

In Mauritania, recent legislation has specifically exempted traditional medicine from the monopoly enjoyed by modern medicine. It is stated in Section 56 of Ordinance No. 83-136 on the practice of the medical professions 28 that the Ordinance does not apply to traditional medicine and traditional pharmacy; they are to be covered by separate legislation. By a Decision adopted in 1981, a working group was established to examine problems concerning traditional medicine and the traditional pharmacopoeia. 28 Section 2 of the Decision reads as follows:

The task of the working group shall be to determine the situation of traditional medicine and the traditional pharmacopoeia in Mauritania and, in particular:

- to examine the most appropriate and realistic ways and means of establishing an honest dialogue between the official health services and traditional practitioners [traitants pratiquant selon les méthodes traditionnelles] in the spirit of the objective of health for all by the year 2000 through primary health care;

- to propose the most appropriate mechanisms for identifying traditional practitioners who are amenable to such a dialogue in order to determine and approve the part that they can play in the system of comprehensive health care (health promotion, prevention of disease and disability, diagnosis and early treatment of disease, and rehabilitation).


On the other hand, in a neighbouring State, Cameroon, a 1966 Law 63 lays down that nothing in the Act is to be construed as prohibiting or preventing the practice of "customary systems of therapeutics", provided that such systems are not dangerous to life or health.

The Medical Practitioners and Dental Surgeons Act, 1968 44 of Uganda prohibits uncensored persons from practising medicine, dentistry, or surgery; however, Section 36 allows the practice of any system of therapeutics by persons recognized by the community to which they belong to be duly trained in such practice, provided the practice is limited to that community only and to that person.

In Malaysia, subsection 1 of Section 34 of the Medical Act, 1971 65 contains a broad general exemption in favour of Malay, Chinese, Indian, or other native methods of therapeutics:

Subject to the provisions of subsection (2) and regulations made under this Act, nothing in this Act shall be deemed to affect the right of any person, not being a person taking or using any name, title, addition or description calculated to induce any person to believe that he is qualified to practise medicine or surgery according to modern scientific methods, to practise systems of therapeutics or surgery according to purely Malay, Chinese, Indian or other native methods, and to demand and recover reasonable charges in respect of such practice.

International Digest of Health Legislation, 1985, 36 (2)
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Another State with an exemption in favour of traditional medicine is Togo. In the first paragraph of Section 68 of the Criminal Code of 1980, the definition of the "illegal practice of medicine" very closely reflects Article L. 372 of the French Public Health Code. Section 69 is included in the Ordinance No. 83-136 on the practice of the medical professions. It is stated that the Ordinance does not apply to traditional medicine and traditional pharmacy; they are to be covered by separate legislation. By a Decision adopted in 1981, a working group was established to examine problems concerning traditional medicine and the traditional pharmacopoeia.

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The tendency in the Commonwealth countries, generally more liberal in recognizing traditional practitioners, can be understood in the light of the former British colonial policies which involved minimum interference with indigenous customs. A typical legislative technique in these countries was to include in the basic medical law provisions exempting all or some forms of traditional medicine from the general limitations on the practice of medicine by non-professionals.

In Sierra Leone, the Medical Practitioners and Dental Surgeons Act, 1966 lays down that nothing in the Act is to be construed as prohibiting or preventing the practice of "customary systems of therapeutics", provided that such systems are not dangerous to life or health.

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Subsection 2 limits the treatment of eye diseases to practitioners of modern medicine. Moreover, under the Poisons Ordinance, 1952, substances listed in that Ordinance may be used only by practitioners of modern medicine, not by traditional healers. The Medicines (Advertisement and Sale) Ordinance, 1956 prohibits practitioners of both forms of medicine from advertising their skills or services.

In Fiji, subsection 2 of Section 40 of the Medical and Dental Practitioners Act, 1971 provides for only a partial exemption in favour of certain forms of traditional medicine:

Nothing in this Act shall affect the lawful occupation trade or business of, or the use of any name or style by, a chiropractor, acupuncturist or chiropodist who possesses such minimum qualifications and experience as may be prescribed... by regulations made under this subsection.

Recent legislation in Kiribati, the Medical and Dental Practitioners Act, 1981, authorizes some aspects of indigenous healing (Section 37):

Nothing in the Medical and Dental Practitioners Ordinance shall affect the right of any I-Kiribati to practice in a responsible manner Kiribati traditional healing by means of herbal therapy, bone-setting and massage, and to demand and recover reasonable charges in respect of such practice.

Likewise, the Health Practitioners Act No. 5 of 1983 of Vanuatu states in Section 17 (Traditional medicine not affected by the Act):

Nothing in this Act shall extend to or affect the practice in good faith by any person of the traditional medicine of the people of Vanuatu if such person is recognized to be competent to exercise such practice according to custom.

Another exemption, limited to licensed persons only, from the prohibition on the practice of medicine by unqualified persons, has been made in favour of certain traditional healers in South Africa. The exemption authorizing the practice of general traditional medicine is laid down in the Homeopaths, Naturopaths, Osteopaths and Herbalists Act, 1974. The relevant provisions, contained in Section 8 (Bantu medicine and herbalists), read as follows:

1. Notwithstanding anything to the contrary in any law contained, a licence to practise as a Bantu medicine man or herbalist shall not be issued unless the authority of the Minister of Health for the issue thereof has first been obtained.

2. The provisions of this Act and of the Medical, Dental and Supplementary Health Professions Act, 1974, shall not be construed as derogating from the right which a Bantu medicine man or herbalist may have by virtue of any licence issued as contemplated in subsection (1).

In contrast to the above approach, which simply exempts traditional medicine from a general prohibition on medical practice, a few countries in Southern Africa have recently enacted legislation that makes more specific provision for the practice of traditional medicine.

In Lesotho, two statutes regulate the practice of traditional medicine and limit the right to practise traditional healing to registered practitioners. Section 2 of the Natural Therapeutic Practitioners Act 1976 defines the term "natural therapeutics" to mean the provision of services for the purpose of preventing, healing, or alleviating sickness or disease or alleviating, preventing, or curing pain "by any means other than those normally recognized by the medical profession". The term includes methods commonly used by homeopathic, naturopathic, osteopathic, chiropractic, acupuncture, and naturopaths. Section 3 prohibits practice as a "natural therapeutist" by any person not registered as such. Applicants for registration must be at least 21 years of age, citizens of Lesotho, and recommended as qualified by the Natural Therapeutic Practitioners Association of Lesotho. The Registrar of the register of natural therapeutics must be satisfied that it is in the public interest that the applicant be permitted to practise. Persons who were practising prior to the date of commencement of the Act are deemed to be qualified. Authorized persons under the Act are prohibited from carrying out certain procedures, including performing operations on or administering injections; practising midwifery; withdrawing blood; treating or offering to treat cancer; performing an internal examination; claiming to be or leading people to infer that he is a "medical practitioner" or "doctor", etc.

The Act also prohibits preventing any person from being treated by a medical practitioner, or improperly influencing him to abstain from such treatment.

Shortly afterwards, the Lesotho Universal Medicinemen and Herbalists Council Act 1978 was enacted. It provided for the establishment of a Universal Medicinemen and Herbalists Council, the objectives of which are (Section 5): (a) to promote and control the activities of medicinemen and herbalists; (b) to provide facilities for the improvement of skills of medicinemen and herbalists; and (c) to bring together all medicinemen and herbalists into one associated group. The Council is required to do all that is necessary to obtain the objectives mentioned in Section 5 and to ensure that every medicineman and herbalist has a valid licence to practise as such. The Council must also keep a register of all its members; membership is open to every medicineman and herbalist who pays the prescribed fee (it is an offence to form or encourage the formation of any other association of medicinemen and herbalists).

In Swaziland, the Control of Natural Therapeutic Practitioners Regulations, 1978 limit the definition of "natural therapeutic practitioners" to persons practising chiropractic, homoeopathy, naturopathy, or electrotherapy. The prohibitions on professional practice are similar to those in force in Lesotho.

Two significant statutes on the practice of traditional medicine were enacted in Zimbabwe in 1981. The first, the Natural Therapists Act, 1981, regulates the organization (through a council) and registration of "natural therapists", a term which includes homoeopaths, naturopaths, and osteopaths (see also p. 328). It is an offence to engage for gain in the practice of these professions or to claim falsely to be a registered natural therapist.
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The second, the Traditional Medical Practitioners Act, 1981,74 is perhaps the most comprehensive piece of legislation on the practice of traditional medicine that has been enacted anywhere in the world. Under the terms of the Act, "practice of traditional medical practitioners" means every act of the object of which is to treat, identify, analyse or diagnose, without the application of operative surgery, any illness of body or mind by traditional methods. The Act establishes a Traditional Medical Practitioners Council, the objectives of which are: to supervise the control and practice of traditional medical practitioners; to promote the practice of traditional medical practitioners and to foster research into, and develop the knowledge of, such practice; to hold inquiries for the purpose of the Act; and to make grants or loans to associations or persons where the Council considers this necessary or desirable for, or incidental to, the attainment of the purpose of the Council. The Minister is to appoint a registrar to establish a register of traditional medical practitioners. The Council is to grant an application for registration if it is satisfied that the applicant possesses sufficient skill and ability to practise as a traditional medical practitioner and is of good character. Where appropriate, the Council may grant the applicant a qualification as a "spirit medium". The Minister of Health may call from registration as an "honorary" traditional medical practitioner, with or without qualification as a spirit medium, to traditional practitioners of "special standing". Registered practitioners are entitled to describe themselves as "registered traditional medical practitioners" or "registered spirit mediums".

An unregistered person commits an offence punishable by up to two years' imprisonment and/or a fine if he: (a) practises or carries on business for gain as a traditional medical practitioner, whether or not purporting to be registered; (b) pretends, or by any means whatsoever holds himself out, to be a registered traditional medical practitioner; or (c) uses the title "Registered Traditional Medical Practitioner" or any name, title, description, or symbol indicating or calculated to lead persons to infer that he is registered as a traditional medical practitioner. Falsely claiming to be a registered spirit medium constitutes a similar offence.

The Council may make by-laws to define "improper or disgraceful conduct" in the case of a registered traditional medical practitioner. A registered practitioner who is found guilty of such conduct, or who is grossly incompetent, is liable to disciplinary measures, which include suspension or removal from the register for a specified period or whether to continue in office. The discipline of the committee to determine by the President. With their comprehensive administrative scope, the functioning of these Acts will doubtless provide an interesting and instructive comparison when contrasted with the operation of the simple general legislation of the practice of traditional medicine hitherto adopted in other jurisdictions.

It has been proposed75 that a disciplinary framework somewhat resembling that outlined above should be adopted in Zaire. Healers' associations would draw up and administer professional codes of ethics. The proper functioning of such a system would, however, be heavily dependent on the professional and ethical standards already prevailing in the Associations and also on the possibility of efficient State control of their decisions.

A common feature of the above-mentioned legislation in Southern Africa is the establishment of associations of traditional healers. Such associations are not a recent phenomenon in some regions of Africa. It is reported76 that since the 19th century associations of herbalists or traditional healers have existed among the Yoruba (a major ethnic group in Western Nigeria, comprising some 16 million people). With the passage of time, a few of these associations "were registered along the lines laid down by the government for trade unions... these associations were charged with the responsibility of drawing up guidelines and codes of conduct to discipline erring members... also to assess the quality of the knowledge of herbalists... certificates of proficiency were issued by some associations..."77.

Dealing with the situation in Zaire, Bibeau78 has proposed that healers' associations be charged with the task of writing "of ethical professional codes" and designated as official regulatory bodies with the duty of enforcing the provisions recorded in their codes of ethics. However, as the question quis custodiet ipsos custodes immediately arises, such a possibility would depend on the professional and moral level of the associations, as well as on the possibility of efficient State control of their decisions.

It may be noted that, even where a form of traditional medicine has been exempted from the monopoly enjoyed by modern medicine in particular countries, this does not necessarily signify the automatic removal of all legal obstacles to useful cooperation between modern health professionals and traditional healers. The usual prohibitions on cooperation with non-physicians that are contained in codes of medical ethics and other legislation regulating professional conduct have not been formally repealed. If future legislation rephrases these provisions in such a way as to demonstrate that cooperation between the practitioners of both systems is not only permitted but desirable, older attitudes hostile to such contacts may be mollified.

The need for such cooperation arises even in developed countries, as is borne out by the following press report from the USA:

In New York, Miami, Sacramento, Calif., and other cities, mental health clinics have brought in spiritists, magic users, and other mystical folk healers to help treat patients, and an increasing number of psychologists advocate using them on a regular basis... Virtually every one of the many ethnic cultures in America has one or more varieties of folk healing tradition... In Miami, a large-scale city project has been set up to bring folk healers into the orthodox medical system not only for psychological treatment but to help resolve the conflicts between the medicine of the streets — which is personal and strongly believed — and the medicine of the hospitals, which is more impersonal and of another culture. About a hundred folk healers were found and are used as consultants in the system."79

International Digest of Health Legislation, 1985, 36 (2)
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The Council may make by-laws to define "improper or disgraceful conduct" in the case of a registered traditional medical practitioner. A registered practitioner who is found guilty of such conduct, or who is grossly incompetent, is liable to disciplinary measures, which include cancellation of registration or suspension for a specified period. It may be noted that, even where a form of traditional medicine has been exempted from the monopoly enjoyed by modern medicine in particular countries, this does not necessarily signify the automatic removal of all legal obstacles to useful cooperation between modern health professionals and traditional healers. The usual prohibitions on cooperation with non-physicians that are contained in codes of ethical ethics and other legislation regulating professional conduct have not been formally repealed. If future legislation rephrases these provisions in such a way as to demonstrate that cooperation between the practitioners of both systems is not only permitted but desirable, older attitudes hostile to such contacts may be mollified.

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In New York, Miami, Sacramento, Calif., and other cities, mental health clinics have brought in spiritists, magic users, and other mystical folk healers to help treat patients, and an increasing number of psychologists advocates using them on a regular basis. Virtually every one of the many ethnic cultures in America has one or more varieties of folk healing tradition... In Miami, a large-scale city project has been set up to bring folk healers into the orthodox medical system not only for psychological treatment but to help resolve the conflicts between the medicine of the streets — which is personal and strongly believed — and the medicine of the hospitals, which is more impersonal and of another culture. About a hundred folk healers were found and are used as consultants in the system.
The inclusive systems

This category of legal regulation of health care covers laws of countries where two or more systems of general health and medical care coexist. This is the position, in law and in practice, in large parts of Southern Asia. In several countries in this continent, systems of traditional medicine are not merely tolerated, but recognized (in addition to medical care based on modern scientific medicine) as a special part of the State-regulated or State-supervised structure of health care, and are supported as such by the governments. There is co-existence, but not yet integration, of the systems.

In order for the systems to operate effectively together, it seems advantageous that the particular traditional system should be formalized to a considerable degree, i.e. have medical traditions, literature, and teaching systems that can be studied and continued. The location at the present time of virtually all "inclusive" and "integrated" systems in South or East Asia is to be explained chiefly by the existence there of sophisticated and stable societies. It is also indicative of the professional level of, for example, the Ayurvedic system that its old as well as recent literature and its leading organizers have placed and continue to place strong emphasis on the need to combat charlatans and quacks.

The traditional systems recognized in South Asia are those based on Ayurveda (including Siddha) and Unani, and their modifications in Burma and Thailand. The homoeopathy associated with those systems also enjoys wide currency.

During the 19th century in South Asia, as elsewhere, Western medicine was considered by the colonial administrations to be the only acceptable system of proper health care, while the overwhelming majority of the population continued to be treated by indigenous practitioners of the traditional systems and by various kinds of folk healers.

Early in the 20th century in India (including territories which are now Bangladesh and Pakistan) and in Ceylon (now Sri Lanka), attempts were made to achieve recognition for traditional practitioners. Rising nationalism was an important factor and the national and State governments reacted: no less than 11 committees on this matter were set up in India between the 1920s and independence. The reports of these committees, the best known being the Usman Report of 1923, recommended State recognition of and support for the Ayurvedic and Unani systems and regulation of professional practice and education. However, when the report of the first comprehensive health survey undertaken in India was submitted by the so-called Bhore Committee, it avoided the issue of traditional medicine. Another all-Indian committee, appointed as a result of a general feeling of disappointment with the Bhore Report, the Chopra Committee, submitted a report in 1948 that strongly recommended full professionalism for Indian traditional medicine and a certain degree of synthesis of Indian medicine with Western medicine. 4

4 The author is indebted to Professor Charles Leslie, University of Delaware, for detailed information on the history of traditional medicine in the Indian subcontinent.
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The following pages provide a summary of the legal situation regarding traditional medicine in South Asia in the years after the end of the Second World War, which were marked by the end of the rule of the former colonial powers and the assertion of their national identities on the part of the indigenous peoples.

India. The legislatures of the Indian States enacted laws to regulate the teaching and practice of and research in Ayurveda and other systems, for example, the Madras Registration of Practitioners of Integrated Medicine Act of 1956, the Mysore Ayurvedic and Unani Practitioners Registration Act of 1962, and the Mysore Homoeopathic Practitioners Act of 1961. The States, which are responsible for the strengthening of traditional colleges, hospitals, dispensaries, and pharmacies, have in almost all cases established State authorities of Indian Medicine for the development of traditional systems.

At the national level, provision for the development of such systems has been included in the Indian Five Year Plans. The sums of money involved show the growing extent of recognition and support. The total sums allocated for the traditional systems of medicine were Rs 4 million in the first Five Year Plan (1951-1956), Rs 160 million in the fourth plan, and Rs 257 million in the fifth. In the 1970s there were 215 hospitals and 14,000 dispensaries in the traditional system. There is a section in the Ministry of Health and Family Planning, headed by an Adviser, to deal with systems of traditional medicine.

In 1969 a Central Council for Research in Indian Medicine and Homoeopathy was established which was responsible, by 1976, for the supervision of 15 research institutions and 130 research units. A Central Council of Indian Medicine, established in 1970, is responsible for regulating the teaching and supervising the practice of Ayurvedic, Siddha, and Unani medicines. The courses of study for a diploma in traditional medicine lasts five-and-a-half years, including internship; three more years are needed to qualify as a specialist. During recent years, the Council has closed around 100 schools of traditional medicine which did not meet its standards. Over 100 schools remain, awarding some 3000 diplomas in traditional medicine each year. In order to practise Indian medicine lawfully, persons who hold diplomas must also be listed in a register and since 1970 the practice of Indian medicine by a person who is not registered has constituted an offence. However, a "grandfather clause" allows persons who had practised for at least five years before 1970 to continue their practice without further conditions, the registration requirements apply only to younger practitioners. It is estimated that the number of registered practitioners in India exceeds 140,000 and that there are still at least 200,000 unregistered traditional practitioners. Only those who are registered can take court proceedings in respect of fees for treatment, hold appointments as physicians in public or semi-public institutions, issue medical certificates, appear as expert witnesses before the courts, and produce and sell medicines.15 In addition, a Central Council of Homoeopathy was established in 1973.16

International Digest of Health Legislation, 1985, 36 (2)
Provisions regulating Ayurvedic and Unani drugs and homoeopathic medicines were introduced by the Drugs and Cosmetics Act, 1940, as amended, and by the Drugs and Cosmetics Rules, 1945, as amended. “Ayurvedic, Siddha and Unani drugs” are defined in the Act as including all medicines intended for internal or external use for or in the diagnosis, treatment, mitigation, or prevention of disease or disorder in human beings or animals and manufactured exclusively in accordance with the formulae described in the authoritative books of the Ayurvedic, Siddha, and Unani Tibb systems of medicine.

In the Rules, the term “homoeopathic medicine” is defined as including any drug which is recorded in homoeopathic provings or has known physiological effects as causing the syndromes which it is administered to alleviate, if it is used in a dose insufficient to cause active physiological effect, but shall not include a drug which is administered by the parenteral route.

The 1982 amendment to the Drugs and Cosmetics Act authorized the Central Government to constitute an advisory body, the Ayurvedic, Siddha and Unani Drugs Consultative Committee, for the purpose of securing uniformity throughout India in the administration of the Act (Section 35D). A licence is required for the manufacture for sale or for distribution of any Ayurvedic, Siddha, or Unani drug (Section 33EEC of the Drugs and Cosmetics Act, as amended).

The industries producing Ayurvedic and other Indian drugs are dispersed throughout the country and employ varied manufacturing processes, old and new, simple and sophisticated. In connection with the last characteristic, it should be mentioned that some of the leading Western pharmaceutical manufacturers participate in research and manufacture in this field, although they have expressed reservations regarding the legal limitations introduced by the governments (for example, the restricted duration of patent protection). Leslie has stated that “indigenous and cosmopolitan medicine are not officially integrated in India as they are in China in a state-sponsored hierarchy of medical institutions”, although substantial de facto integration between the different sections of the Indian medical system exists. He calls it a “dual system”. Another authority considers attempts at integration to be “premature and prejudicial to the Indian systems which are several centuries belated.... Integration is to come later, as a matter of the next generation”. However, a process of interchange can already be observed.

Pakistan. In 1962, an Ordinance was issued “to prevent the misuse of the allopathic system”. It provided that only registered medical practitioners were entitled to use the title “doctor”, to perform surgery, or to prescribe any specially listed antibiotics or dangerous drugs. These prohibitions were also applicable to practitioners of traditional medicine, it being prescribed that “No person practising the allopathic, homoeopathic, Ayurvedic, etc. system of medicine may use the title of ‘doctor’, unless he is a registered medical practi-
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Sri Lanka. The interest in traditional medicine and the activity of the profession even prior to independence led to the promulgation of the Indigenous Medicine Ordinance in 1941; this Ordinance provided for the establishment as governmental institutions of the Board of Indigenous Medicine (whose duties included the registration of practitioners), the College of Indigenous Medicine, and the Hospital of Indigenous Medicine.

The establishment of a Department of Ayurveda within the Ministry of Health by the Ayurveda Act, No. 31 of 1961 constituted a veritable landmark in the modern history of Ayurveda (defined in the Act to include the Siddha and Unani systems, and any other system indigenous to Asian countries).

The objects of the Department were defined as follows: the provision of establishments and services necessary for the treatment of disease, and generally for the preservation and promotion of the health of the people according to Ayurveda; the encouragement of the study of, and research into, Ayurveda by the grant of scholarships and other facilities to persons employed or proposed to be employed in the Department and by the grant of financial aid and other assistance to institutions providing courses of study or engaging in research into Ayurveda; and the taking, developing, or encouragement of measures for the investigation of disease, and for the improvement of public health according to Ayurveda. 19

The Act also specified the duties of the Ayurvedic Medical Council (responsible, \textit{inter alia}, for the registration of Ayurvedic physicians, pharmacists, and nurses and for the regulation of their professional conduct), the Ayurvedic College and Hospital Board, and the Ayurvedic Research Committee.

The Ayurvedic Physicians Professional Conduct Rules, 1971 were made under Section 18 of the above-mentioned Act by the Ayurvedic Medical Council and approved by the Ministry of Health. They establish a code of ethics for Ayurvedic physicians, the following, in particular, being considered professional misconduct: (a) procuring or attempting to procure an abortion or miscarriage; (b) issuing any certificate regarding the efficacy of any Ayurvedic drug or any Ayurvedic pharmaceutical product, containing statements which the practitioner knows to be untrue or misleading; (c) conviction of an offence (committed in the practitioner’s professional capacity) under the Poisons, Opium and Dangerous Drugs Ordinance; (d) selling to the public, either directly or indirectly, any Ayurvedic pharmaceutical product for which the prior sanction of the Ayurvedic Formulary Committee has not been obtained; and (e) exhibiting or displaying any medical degree or medical diploma which has not been approved by the Ayurvedic Medical Council. 20

Detailed hygienic and other standards to be fulfilled by Ayurvedic pharmacies were laid down in the Ayurvedic Pharmacies Regulations, 1973. 21

The importance attached by the Sri Lanka Government to Ayurveda was further recognized by the establishment in early 1980 of the Ministry of Indigenous Medicine as a separate department, with a senior Parliamentarian, himself an Ayurvedic practitioner by profession, in charge. 22

The recent history of traditional medicine of Sri Lanka shows the difficulties involved in attempts to integrate Ayurvedic with modern medicine. In 1946, a Commission was appointed, \textit{inter alia}, to advise on the measures to be adopted for fostering research into the systems of indigenous medicine. The widely-divergent views of certain members of the Commission regarding the use of modern drugs by Ayurvedic practitioners have been noted by Jayasuriya, 23 who cites some remarkable excerpts from the Commission’s Report:

... “the use of allopathic medicine and methods of treatment in ayurvedic hospitals was generally opposed by bodies representative of allopathy as well as ayurveda”. Some had advocated the maintenance of ayurveda in its pristine concept, others were supporters of western medicine and methods of treatment and had maintained that there were ayurvedic remedies for all diseases and disease conditions and suggested their revival and incorporation in the ayurvedic pharmacopoeia.... “We feel that the proper course to follow is to steer clear of the Scylla of extensive westernization and the Charybdis of existing stagnation. We, therefore, recommend the use in ayurvedic hospitals of such allopathic medicines as are considered vital to the treatment of diseases at the present stage of development of ayurveda. We desire to stress that in making this recommendation we are guided by the conviction that the interests of the sick transcend all other considerations. This recommendation should not be construed as granting a carte blanche to all ayurvedic physicians to use allopathic medicines. Authority to prescribe allopathic drugs should be restricted to those who have been trained in the use of such drugs in recognised institutions. It would be a matter for the Council of Ayurvedic Medicine to decide the number and nature of such drugs for use in ayurvedic hospitals and dispensaries. We must reiterate, however, that these allopathic medicines are to be used in exceptional cases only and that in all other cases the use of ayurvedic medicines should be encouraged and resorted to”.

The provisions of the Homoeopathy Act of 1970 are discussed below (see p. 327).

Burma. Burmese indigenous medicine is based on Ayurvedic concepts and has been influenced by Buddhist philosophy. Prior to the Second World War certain committees recommended that this system be recognized by the Government, but no action resulted. Four years after Burma attained its independence in 1948, the Burmese Indigenous Medical Committee was formed. It drafted the Indigenous Burmese Medical Practitioners Board Act, which was passed in 1953, 24 with amendments in 1955 and 1962. It established an Indigenous Burmese Medical Practitioners Board, whose functions are to advise the Government on, \textit{inter alia}, the revival and development of indigenous Burmese
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Section 7 of the Indigenous Burmese Medical Practitioners Board Rules, 1955 provides for the registration of such practitioners in six classes. The system of classification is essentially based on the division of Burmese medicine into four branches (dhatu, Ayurveda, astrology, and witchcraft). In Section 9 of the Rules, details are given of the knowledge required for registration in the particular classes. Provision is also made, in Section 10, for authors of works on indigenous medicine to be registered in one of three classes; it is indicated in this Section that monks may not be registered as medical practitioners.

Under Section 12 of the Rules, the Board is empowered (subject to the prior sanction of the Head of State) to prescribe qualifications for registration, and to terminate the services of any or all of the members of the Board and appoint new members in their place. Under these powers a new Board was appointed to initiate the re-registration of practitioners. It is also reported that an educational institution known as the Institute of Indigenous Medicine was established in 1976.

Thailand. Traditional healing practices have been recognized in Thailand as a branch of the “art of healing”. The original 1936 Act for the control of the practice of the art of healing was re-enacted under the same title as Act No. 7 of 30 December 1966 (subsequently amended by an Act dated 30 September 1968). Its provisions cover the practice of medicine, dentistry, pharmacy, nursing, and midwifery. An applicant who wishes to be registered and licensed as a practitioner in the “old-fashioned art of healing” is required to undergo a course of training and instruction lasting not less than three years, with a registered and licensed practitioner, and must pass an examination set by the Commission for the Control of the Practice of the Art of Healing. Examinations are held once a year; however, it is reported that the failure rate is very high. All types of traditional practitioners are registered with the Medical Registration Division of the Ministry of Public Health.

Under the Drugs Act 1967, as last amended by the Drugs Act (No. 3) 1979, a licence is required in order to engage in the manufacture, importation, and sale of drugs, both modern and “old-fashioned”. The latter are defined in Section 4 of the Act as “drugs intended for use in the practice of the old-fashioned art of healing or veterinary medicine, included in the old-fashioned pharmacopoeias notified by the Minister [of Health] or drugs declared by the Minister to be old-fashioned drugs or drugs whose formula has been granted registration as an old-fashioned drug”.

Indonesia. Although traditional healers and birth attendants (dukuns) play an important part in the life of more than 300 ethnic groups dispersed over 13,000 islands, there is little legislation regulating traditional medicine. Dukuns are allowed to practise without any licence or registration. However, in 1974, the Ministry of Health registered 65,641 traditional midwives, who, according to the Ministry’s estimate, attended 80-90% of all births in rural areas.

Three Ministerial Regulations issued in 1976 deal with the production, distribution, registration, and labelling of traditional drugs. A traditional drug is defined as a ready-for-use or packaged drug derived from constituents of plants, animals, minerals, and/or galenical preparations, or a mixture of the above, for which clinical data are not yet available and which is used for treatment purposes on the basis of experience. Unpackaged traditional drugs in liquid or other form that are sold without labelling, and other traditional drugs prepared and sold by individuals without labelling, need not be registered. Traditional drugs may not be advertised as effective in treating or preventing diseases, or in relation to sexual impotence, pregnancy, and abortion, except with the approval of the Minister of Health.

Democratic Kampuchea. A Law on the organization of traditional therapeutics and the traditional pharmacopoeia was enacted in 1964 in what was then Cambodia (now Democratic Kampuchea). This Law defines “traditional therapeutics” as treatment and care using traditional methods, this expression excluding surgical and obstetrical procedures and dental surgery, and also official methods of therapy and analysis whatever they may be (electrical, chemical, or bacteriological). The “traditional pharmacopoeia” is defined as the book of formulae for traditional medicaments and the art of preparing them, this expression excluding chemical products and synthetic and industrial medicaments with galenical formulae prepared according to the techniques of the official pharmacopoeia.
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Under Section 12 of the Rules, the Board is to seek ways and means of consolidating into a single system the four branches of medicine currently practised; the Board is likewise to undertake studies and research and advise the competent authorities on standardizing the methods of treatment provided in dispensaries operated by the Government.

The Indigenous Burmese Medical Practitioners Board Amendment Act of 1962 introduced new Sections 22-A and 28-A empowering the Chairman of the Revolutionary Council of Burma to (a) cancel the registration of indigenous medical practitioners, (b) prescribe qualifications for registration, and (c) terminate the services of any or all of the members of the Board and appoint new members in their place. Under these powers a new Board was appointed to initiate the re-registration of practitioners. It is also reported that an educational institution known as the Institute of Indigenous Medicine was established in 1976.

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International Digest of Health Legislation, 1985, 36 (2)

TRADITIONAL AND ALTERNATIVE SYSTEMS OF MEDICINE

Traditional therapists, manufacturers of traditional medicaments, and vendors of simple or medicinal plants or herbalists must be at least 25 years old and must possess a licence to practise issued by the Minister of Health following completion of a three-year apprenticeship. They are prohibited from practising their profession on the premises of health care establishments. The commercial advertising of traditional medicaments is prohibited.107

Hong Kong. Both modern and traditional systems of medicine are officially recognized and are administered as separate systems. The situation before 1974 has been described in detail by Lee and by Topley.108

The integrated systems

In the countries covered by what has been described as the “inclusive” category, practitioners of traditional systems of medicine are recognized and their work is fully legalized and regulated by law; they may be employed in public health institutions and perform some official medical functions. Nevertheless they still form a system that is separated from the main structure of health care, which, since the 19th century, has essentially been based on modern scientific medicine. The two systems in that category are not yet integrated in the sense that professionals trained in the different systems of medicine do not work together as members of a single national health care network. Under policies advocated by the World Health Organization, some form of integration of modern and traditional medicine should be attempted in order to meet health care needs as fully as possible. It seems that at present traditional medicine is properly integrated into the health care systems of only one State, namely China and, perhaps, Nepal also. The difficulty that arises in summarizing legal aspects of health care in these States derives not only from the lack of accurate information but also from the absence of the normal legal, i.e. statutory, regulation of medicine. In another State, the Democratic People’s Republic of Korea, there are indications of a policy to integrate the two systems in the Public Health Law adopted on 3 April 1980.

China. In the first half of the 20th century, the health services in China were organized on the basis of modern medicine. The revival of Chinese traditional medicine in China has resulted in a unique system of health care which seems to be truly integrated with its modern counterpart.

The procedures and structure of the health care apparatus are determined by Communist Party policies, and their implementation is undertaken by representative agencies in the field. Roemer has declared that one of the proclaimed political principles in China was to unite traditional and Western medicine. He states that:

... it was important to the new government to assure that everyone had access to health care. This meant that traditional doctors, with their herbs, acupuncture, and moxibustion, must be used to serve the people. By “uniting with Western medicine”, the strategy has been to culminate those elements of ancient Chinese healing which are effective and discard what is not.109

Every Western-style medical school in China (85 of them) contains a department of traditional medicine; similarly, the smaller number of traditional medicine schools each contains a department of Western medicine.110

Practitioners of Chinese medicine are also employed in modern hospitals.

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Hillier and Jewell reported in 1983112 that the All China Association of Traditional Chinese Medicine, dissolved during the Cultural Revolution, has been revived, and that the Tianjin College of Traditional Medicine, closed in 1969, has been re-opened, and now offers a five-year course. In December 1982, it was announced that an institute for combining traditional Chinese and Western medicine had been established. Hillier and Jewell state however that a “distinction should always be maintained between the official policy of the integration of traditional and Western medicine, and the survival of traditional medicine in day-to-day health care in China”.113

In a statement during the course of the Thirty-eighth World Health Assembly held in Geneva in May 1985, one of the delegates of China noted that his country had always attached great importance to traditional medicine, and its hospitals actively funded its development. There are over 1200 hospitals, with 87,000 beds, devoted entirely to traditional medicine. China currently has 320,000 traditional medicine staff, and schools for training at all levels have been set up. There are also numerous traditional medicine research institutions.114

The network of barefoot doctors, unique to the Chinese system, cannot be seen as forming part of traditional medicine properly so-called. “Barefoot doctors”, who receive a short but intensive course of training in primary health care in both systems, belong instead to the category of “doctor substitutes” or “physician assistants”.

A cautionary warning is sometimes formulated to the effect that certain successes of China’s health care system are not likely to be repeated in other countries simply by imitating China’s methods. The system works in China as it does due to the Chinese political system, and more particularly to its economic policy. Consequently, it remains a question to what extent other countries can hope to imitate China’s system of health care without adopting its economic and other policies.

Nepal. The policy of the Government, based on five-year plans, involves a system of integrated health services in which both modern and Ayurvedic medicine are applied. Ayurvedic clinics are considered...
Traditional therapists, manufacturers of traditional medicaments, and vendors of simple or medicinal plants or herbalists must be at least 25 years old and must possess a licence to practise issued by the Minister of Health following completion of a three-year apprenticeship. They are prohibited from practising their profession on the premises of health care establishments. The commercial advertising of traditional medicaments is prohibited.107

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Western-style and traditional Chinese doctors work together at the commune health center according to the policy of integrating the two systems of medicine. Patients may seek either type of doctor for treatment. Brigade-based services carried out preventive public health measures, although some curative services provided by traditional doctors were also available.111

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TECHNICAL ASSISTANCE TO DEVELOPMENT

3. SELECTED BRANCHES OF ALTERNATIVE MEDICINE

Four kinds of traditional or “alternative” health occupations merit brief special attention since they present particular features.

Traditional birth attendants

Traditional birth attendants in Africa, Asia, and Latin America are reputed to deliver a very large proportion of babies (probably amounting to two-thirds of the neonates in the world) and thus are often accorded particular attention by health care administrators and legislators in those regions. Throughout the developing world, the trend is towards providing traditional birth attendants with some formal training, as until recently their position and work in the community were to be part of the basic health services. There is an Ayurvedic Section in the Office of the Director General of Health Services. The programmes for health services included in the Fifth Five-Year Plan make provision for four Ayurvedic hospitals in each of the four development regions. There is an Ayurvedic Governmental Pharmaceutical Unit, whose objective is to provide inexpensive medicaments. Formal education in the Ayurvedic system is under the supervision of the Institute of Medicine of Tribhuvon University.115 It has been reported that, because of an acute shortage of medical personnel, the Nepalese Government has decided to make use of 400,000 faith healers [dhamis jhankris] in remote villages.116

Democratic People’s Republic of Korea. Under Section 15 of the Public Health Law adopted in April 1980,117 the State is required, with a view to preserving national therapeutic traditions, to combine traditional therapeutic methods with modern diagnosis in medical establishments. Under Section 29, health establishments and medical research centres in the country are required to intensify research designed to give traditional medicine a scientific basis, with a view to developing a systematic theory of traditional medicine and further developing traditional medicine and folk remedies. Section 36 prescribes that the State is to consolidate centres producing traditional drugs, and is to train establishments, undertakings, organizations, and even individual citizens in the cultivation and collection of medicinal plants. Establishments engaged in the production of traditional drugs and other establishments concerned are required to protect, expand, and exploit systematically national sources of such drugs.

These provisions may seem to indicate that governmental policy is to integrate modern and traditional medicine. However, the wording employed is general (“combine methods”, “consolidate centres”), and some knowledge of the actual implementation of the Public Health Law may be needed to show if the DPRK system can be regarded as initiating “integration” in terms of the classification made above.

The position in Ecuador is not necessarily typical of the situation of traditional birth attendants in South America. Mexican legislation is based solely on apprenticeship and experience. An excellent, exhaustive report on the status of traditional birth attendants throughout the world, from which most of the following data are taken, was published in 1980.119

The position in 1979 was that traditional birth attendants were registered and/or licensed in 33 developing countries (eight in South and South-East Asia, three in the Middle East, 10 in Africa, and 12 in South and Central America). In 1973, a survey undertaken by WHO found that they were in some way legally recognized or registered in 26 countries. Prohibitive legislation exists in some countries in the Middle East (Egypt, Lebanon, and Tunisia), although in practice it is not enforced. In a few countries (such as the Philippines and Belize), traditional birth attendants may legally work only in areas where physicians or registered midwives are not available. In several countries considerable efforts are being made by governments to register and train traditional birth attendants and to integrate them into the health care systems, particularly in rural areas (these countries include Afghanistan, Costa Rica, India, Malaysia, Mexico, Panama, and Thailand).

The large number of traditional birth attendants, the universal respect they enjoy in their communities (except, for cultural and caste reasons, in the Indian subcontinent), and the constant demand for their services make these practitioners an important factor in the policy of any health care administration. In addition to their primary tasks in taking care of deliveries, they may be employed in certain countries as auxiliaries in teaching hygiene, in family planning, and in efforts to eradicate harmful or inhumane customs (such as female circumcision).

Old-fashioned legislation, which does not exist only in countries with the “exclusive” system of health care, made the activities of traditional birth attendants unlawful by strict general prohibitions. Thus, as late as 1971, the Ecuadorian Health Code120 limited the practice of physicians, pharmacists, dentists, midwives, etc. to persons holding qualifications “granted or validated by a university in Ecuador” (Section 174); health authorities were responsible for detecting and suppressing the illegal practice of medicine and allied professions, “without prejudice to normal judicial proceedings” (Section 179). Section 180 indeed provides that “if, without holding a legally conferred qualification, diploma, or certificate, he possesses equipment or materials for such practice”, he is “guilty of... if, without holding a legally conferred qualification, diploma, or certificate, he possesses equipment or materials for such practice”.

The position in Ecuador is not necessarily typical of the situation of traditional birth attendants in South America. Mexican legislation providing an interesting contrast. Thus the Regulations of 20 October 1976 on qualified lay birth attendants121 mark out a distinct sector of the health field where such attendants [parteros empiricos] are entitled to practise. Section 2 of the Regulations defines these attendants as persons who have been attending deliveries without training and are licensed and qualified under the Regulations. The requirements of the Regulations regarding qualification are that the persons in question

International Digest of Health Legislation, 1985, 36 (2)
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should be licensed by a health centre, after following an appropriate course of training. Under Section 9, entry to the course of training is restricted to persons who have attained majority, are literate, and are recognized by the communities in which they work as carrying out obstetric activities. Section 13 specifies that attendants may: attend women in their community during normal pregnancy, delivery, and the puerperium provided that they notify the competent health centre; and prescribe appropriate medicaments in accordance with the instructions of the Secretariat for Health and Welfare.

Honduras and, in Africa, Liberia have also enacted legislation specifically regulating traditional birth attendants. Bolivian Regulations of 1982 on the conduct of family health activities authorize a newly established agency, the National Division of Maternal and Child Health, to lay down regulations concerning traditional birth attendants. 

In Malaysia, the Midwives (Registration) Regulations, 1971 have afforded traditional birth attendants a broad opportunity to legalize their practice. The following is an extract from subsection 2 of Section 11 of the Regulations: 

The following persons shall be eligible to practise as midwives...

- any person untrained in the practice of midwifery, who within four years of the commencement of [the Midwives Act, 1966] satisfies the Registrar that such person has during a period of two years immediately preceding application for registration... attended to women during childbirth....

A substantial article by Owen on the legal position of traditional birth attendants has recently been published, and this constitutes a most valuable reference work.

Acupuncturists

Over the last two decades, acupuncture has come to be accepted as a new technique of medicine in several countries outside its Chinese homeland. However, the approaches to regulation of acupuncture have varied.

In countries with “exclusive” systems, such as France, Belgium, or the East European socialist countries, acupuncture may be performed only by physicians. Special training in acupuncture is available for physicians in France, but no specialization in acupuncture is recognized. In Czechoslovakia, Methodological Directives of the Czech Ministry of Health, while recognizing acupuncture as a method of treatment, restrict its practice to certain departments of health institutions and to medical specialists who have attended an organized course.

In Switzerland, the social insurance agencies considered that acupuncture had not been scientifically proved efficacious and therefore was not covered by social insurance. However, in 1980 the Federal Bureau of Social Insurance issued a Circular under which acupuncture treatment lasting 15-20 minutes and provided by a physician in connection with a consultation is covered by social insurance. A Federal insurance court upheld this regulation in a 1983 decision.

in the Federal Republic of Germany, on the other hand, persons authorized to practise as lay health practitioners are entitled to practise acupuncture. In the United Kingdom and certain other countries with a “tolerant” system, acupuncture is not restricted to physicians or other licensed professions. However, it seems that this is not the case in Denmark and Norway, where acupuncture appears to be considered a surgical procedure. Special provisions regulating the practice of acupuncture already exist in a small number of developing countries. In Algeria (where the 1976 Public Health Code introduced an interesting mixture of French and socialist systems of health care), a category of specialized “nurse-acupuncturists” was established by an Order dated 10 April 1976. In Fiji, the lawful practice of acupuncture is subject to registration by the Permanent Secretary for Health. Applicants for registration must prove either that they are licensed as acupuncturists in any of the States of the USA or in the United Kingdom, Canada, or New Zealand, or that they possess a certificate from the health authorities in China, the Province of Taiwan, Hong Kong, Singapore, or the Philippines to the effect that they have practised acupuncture in any of those countries for a period of not less than three years. In Guatemala, a 1977 Order established the Guatemalan Association of Acupuncture, to promote the knowledge and the study of acupuncture and to facilitate professional contacts with acupuncturists in other countries. Membership of this Association does not, however, license the person concerned to practise acupuncture.

In the Philippines, Resolution No. 31 of the Board of Medicine of 2 March 1983 states that acupuncture is to be recognized as “a modality of treatment for certain ailments to be practiced only by registered physicians in the Philippines”. The Board is to promulgate rules and regulations to govern the practice of acupuncture as a modality of treatment. Such rules and regulations are to provide, inter alia, that “recognized practitioners of acupuncture must submit every December each year a complete report on their experiences and the results of their clinical treatment of cases to the Board of Medicine”.

Many of the States of the USA make legal provision for the practice of acupuncture. At the Federal level, acupuncture needles and equipment are covered by Section 505 of the Federal Food, Drug, and Cosmetic Act, which deals with the labelling of drugs and devices. In 1973, acupuncture was declared by the Food and Drug Administration (FDA) to be a method for investigational use by licensed practitioners only “until substantial scientific evidence is obtained by valid research studies supporting the safety and therapeutic usefulness of acupuncture devices”. The FDA at that time published a notice prescribing labelling requirements for such devices, including the following warning: “Cautions: experimental device limited to investigational use by or under the direct supervision of a medical or dental practitioner”. According to FDA Regulations, such devices were to be used only under the standard conditions prescribed for research involving human subjects.
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In 1973 in the State of New York, the State Commission on Acupuncture submitted a report recommending limitation of the lawful use of acupuncture procedures to licensed acupuncturists under the supervision of a physician "as investigational and experimental forms of medical and dental practice"—with a view to lifting that limitation "as rapidly as accumulated data will permit". On the recommendation of the Commission, the New York legislature in 1974 passed an Act the purpose of which was stated to be as follows:[13]

... to presently provide for the furnishing of acupuncture only: (1) within the context of a co-ordinated, State-wide scientifically and medically valid research effort; (2) by qualified practitioners; (3) to informed, consenting recipients; and (4) subject to on-going review and evaluation by recognized medical authorities.

The Act empowered the State Boards responsible for medicine and dentistry to formulate rules and regulations governing the provision of acupuncture and to establish licensing procedures for its practice in New York State (the main prerequisites for a licence being that the applicant must have practised acupuncture for at least 10 years, and must have a licence "as a doctor of acupuncture, herb physician, or doctor of traditional Chinese medicine duly issued by the licensing board of any foreign country").

During the 1970s, the legislatures of several States of the USA, sometimes under the influence of acupuncturists' lobbies, established conditions for the licensing of acupuncturists who were not physicians. Thus, as of 1981 non-physicians were permitted to practise acupuncture under various conditions in at least 15 States.13 Under an Act enacted in 1978 in the State of Rhode Island,13 no treatment by acupuncture:

shall be performed unless within a period of 12 months preceding the treatment the patient shall have undergone a diagnostic examination by a duly licensed and registered physician with regard to his illness or malady. The doctor of acupuncture (as defined in the Act) or the licensed acupuncture assistant (likewise defined) shall first... be familiar with the results of the said diagnostic examination.

The Act provides for the establishment of a State Board of Acupuncture, and also defines the conditions under which the Board may issue licences to practise acupuncture or as an acupuncture assistant.

The conditions for the issue of a licence in Rhode Island are as follows: (a) the applicant must have successfully completed a course of study of 36 months in acupuncture at a college in Hong Kong or have qualifications considered equivalent by the State Board of Acupuncture; (b) the applicant must have practised acupuncture for 10 years; and (c) the applicant must have passed the examinations set by the Board.

In Florida, legislation enacted in 1980 defines acupuncture as "the insertion of needles into the human body... for the purpose of controlling and regulating the flow and balance of energy in the body". Only persons certified by the Department of Professional Regulation may practise acupuncture. Among the conditions laid down for certification are: the applicant must be at least 18 years of age; the applicant must have undertaken two years of education in acupuncture in a school or college approved by the Department (experience may be substituted for a part of this training); and the applicant must pass an examination. It is a misdemeanour to practise acupuncture without a valid certificate.

An extensive set of provisions regulating the profession has been laid down in California's Business and Professions Code.13 The State has appointed an Acupuncture Advisory Committee consisting of seven members of whom five must be acupuncturists with 10 years' experience (not being physicians), and two acupuncturists with two years' experience and possessing a physician's and surgeon's certificate. Prerequisites for the issuance of a certificate are that the applicant must be at least 18 years of age, be of good moral character, have completed an approved course in acupuncture or have two years' experience of practising acupuncture, and have passed an examination administered by the appropriate Board. In addition, an applicant who can produce reasonable proof that he has performed acupuncture for five (under some circumstances only three) years may be certified. Practising acupuncture without a certificate is a misdemeanour, and acupuncture may not be performed on a patient without a prior diagnosis or referral from a licensed physician and surgeon, dentist, podiatrist, or chiropractor.

Some representatives of scientific medicine in the USA believe that acupuncture, if modernized in accordance with US standards, can now be placed on a solid scientific basis. On the other hand, one author is of the opinion (to some extent based on the decision of a Texas court in Andrews v. Ballard), that "physicians are technically untrained in the performance of acupuncture and professionally uneducated in its underlying principles"; somewhat surprisingly, he concludes that "the... physician will have only a minor role to play in regulating those unorthodox techniques that do not even seek a western scientific justification".

Manipulative therapy (chiropractic and osteopathy)

The therapy provided by these professions essentially consists of the manipulation of various parts of the body, particularly (in the case of chiropractic) of the spine. Such healing methods are based on theories that are considered irrational, or at the very least unproved, by modern scientific medicine. However, owing to the successes of manipulative...
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Regulation may practise acupuncture. Among the conditions laid down
for certification are: the applicant must be at least 18 years of age; the
applicant must have undertaken two years of education in acupuncture
in a school or college approved by the Department (experience may be
substituted for a part of this training); and the applicant must pass an
examination. It is a misdemeanour to practise acupuncture without a
valid certificate.

An extensive set of provisions regulating the profession has been
laid down in California’s Business and Professions Code. The State
has appointed an Acupuncture Advisory Committee consisting of seven
members of whom five must be acupuncturists with 10 years’ experience
(not being physicians), and two acupuncturists with two years’
experience and possessing a physician’s and surgeon’s certificate. Prere-
quisites for the issuance of a certificate are that the applicant must be at
least 18 years of age, be of good moral character, have completed an
approved course in acupuncture or have two years’ experience of prac-
tising acupuncture, and have passed an examination administered by the
appropriate Board. In addition, an applicant who can produce reasonable proof that he has performed acupuncture for five (under
some circumstances only three) years may be certified. Practising
acupuncture without a certificate is a misdemeanour, and acupuncture
may not be performed on a patient without a prior diagnosis or referral
from a licensed physician and surgeon, dentist, podiatrist, or
chiropractor.

Some representatives of scientific medicine in the USA believe that
acupuncture, if modernized in accordance with US standards, can now
be placed on a solid scientific basis. On the other hand, one author
is of the opinion (to some extent based on the decision of a Texas court
in Andrews v. Ballard), that “physicians are technically untrained in the
performance of acupuncture and professionally uneducated in its
underlying principles”; somewhat surprisingly, he concludes that “the...
physician will have only a minor role to play in regulating those
unorthodox techniques that do not even seek a western scientific
justification”.

Manipulative therapy (chiropractic and osteopathy)

The therapy provided by these professions essentially consists of the
manipulation of various parts of the body, particularly (in the case of
chiropractic) of the spine. Such healing methods are based on theories
that are considered irrational, or at the very least unproved, by modern
scientific medicine. However, owing to the successes of manipulative
therapy in some cases and also to disenchantment with orthodox treatment, chiropractors and osteopaths are accepted as satisfactory "alternative" therapists among certain sectors of the population. Throughout the world, the practice of manipulative therapy and the status of its practitioners are regulated by a considerable body of legislation.

In some countries with an "exclusive" system of health care, manipulative therapy is restricted to physicians; this is typically the case in France and Belgium. Under Section 2 of a French Order dated 6 January 1962, as amended, manipulative therapy is listed among the medical acts that may be performed only by orthodox medical professionals.

The following medical acts may be performed only by doctors of medicine: 9

1. Any forced movement of the joints and any reduction of bone displacement, as well as manipulation of the vertebrae and, in general, all types of treatment known as osteopathy, spondylotherapy (or vertebrotherapy), and chiropractic.

French law does not allow qualified auxiliaries to provide such treatment, even under the direct supervision of a physician. Education in chiropractic methods was introduced into the curriculum for medical students by an Order dated 11 February 1953.106 Methodological Directives on the legal registration of chiropractic ("manual medicine") were issued in Czechoslovakia in 1977 by the Czech Ministry of Health.144 Section 4 of these Directives prescribes that "manual medicine" may be practised only by physicians holding specialist qualifications in any clinical field and having successfully completed a special course of training. "Manual medicine" is defined in Section 1 as a method of curative and preventive care of painful conditions and painful diseases of the peripheral joints which are not caused by major organic changes but by functional disturbances and reflex changes arising from such disturbances. The treatment (following evaluation of the results of radiological, neurological, and other examinations) includes manipulations selected according to the functional disturbances diagnosed, "soft" techniques, and mobilizing techniques (gradual restoration of mobility).

In contrast to health care systems which restrict chiropractic to physicians, the legal provisions in the United Kingdom do not require that chiropractors should have any qualifications in order to practise; in other words, they are free to practise (even for gain) subject to the general limitations mentioned earlier (see p. 293). There is no legislation in the United Kingdom specifically regulating chiropractors and osteopaths, although both types of practitioner are fairly numerous. They are organized under the British Chiropractic Association and the British Osteopathic Association, such as the Anglo-European School of Chiropractic and the British School of Osteopathy. As mentioned earlier, the services of chiropractors and osteopaths are not available through the National Health Service.

In the Federal Republic of Germany, chiropractors, like acupuncturists, may practise if they are authorized to practise as lay health practitioners (see p. 292). The same applies to lay health practitioners who have continued to practise in the German Democratic Republic (see p. 292).

European countries generally have no legislation establishing chiropractic or osteopathy as separate "alternative" health professions, although associations such as those mentioned above have attempted to obtain statutory recognition of their professions. In contrast, it is a common feature of health legislation in the United States and Canada that manipulative therapists are recognized as forming a special health profession and that registered practitioners are afforded a monopoly. Special statutes regulating the practice of manipulative therapy exist in nearly every State of the USA142 and in at least seven Canadian Provinces;143 practice is restricted to persons who fulfill certain conditions and, as a rule, have been registered and/or licensed. Practising without a licence is in many cases an offence. Thus, the professions of chiropractor, osteopath, naturopath, and "drugless practitioner" (see below) are protected by law in North America. Such legislation came into being partly through the efforts of the practitioners themselves (who, without special laws, would be prohibited from practising on the general monopoly afforded to practicing physicians) and partly through the determination of the States and Provinces to establish some form of legal control over health-related activities affecting many people.

As an example, Sections 6551-6556 of Book 16 of the Consolidated Laws of New York144 regulate chiropractic, which is defined as:

...detecting and correcting by manual or mechanical means structural imbalance, distortion, or subluxations in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is a result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Under the New York statute, chiropractors may not treat certain specified diseases, may not perform operations or reduce fractures or dislocations, and may not prescribe, administer, dispense, or otherwise use in their practice drugs or medicaments. Only licensed persons may practise chiropractic and use the title of "chiropractor". The conditions of eligibility for a professional licence include training comprising two years of preprofessional college study and a four-year resident programme in chiropractic, satisfactory experience, and passing of an examination.

US regulators sometimes consider practitioners of manipulative therapy at the same level professionally as physicians. Thus, Part 59 of Title 21 of the US Code of Federal Regulations includes "osteopathic general practice" in the definition of family medicine.145 In the Canadian Province of Ontario, the professions of chiropractic, osteopathy, etc. have been regulated by the Drugless Practitioners Act and the Regulations for its implementation.146 Only persons...
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registered under this Act may practise as chiropractors or osteopaths or use such titles. They may not prescribe or administer drugs, use anaesthetics, or practise surgery or midwifery. Unauthorized practice constitutes a criminal offence. The requirements for registration include passing an examination following completion of a four-year course specified in the Regulations (the educational and examination requirements are somewhat more demanding for osteopathy than for chiropractic). While the definition of osteopathy in the Regulations is very vague ("treatment by ... methods taught at colleges of osteopathy and approved by the Board"), the definition of chiropractic is more specific:

... treatment of persons by the relief of interference with the normal functioning of the nervous system of the body by the adjustment or the manipulation or both of the articulations and the tissues thereof, more especially those of the spinal column and when necessary the aid of (a) exercise, (b) light, (c) thermotherapy, (d) hydrotherapy, or (e) electrotherapy.

In South Africa, the Chiropractors Act of 1971\footnote{\textsuperscript{47}} empowers the Department of Health to draw up a list of persons authorized to practise chiropractic for gain; it is a criminal offence to practise without being on the list. The Chiropractic Association of South Africa is empowered to make rules prescribing the conditions regulating the practice of chiropractors and their scale of fees; such rules must be approved by the Minister of Health and published in the Government Gazette. The Association also has power to prescribe penalties for contraventions against such rules. (This power appears to conflict with the widely accepted principle that criminal penalties may be imposed only if they have been previously determined by law and not simply fixed, for instance, by a professional association). The profession of osteopathy was recognized in an essentially similar manner by the Homeopaths, Naturopaths, Osteopaths and Herbalists Act, 1974.\footnote{\textsuperscript{48}}

In Australia and New Zealand, there is a long history of efforts by associations of chiropractors and osteopaths to overcome the opposition of practitioners of orthodox medicine in order to obtain statutory recognition of their professions. In both countries, extensive reports by parliamentary commissions have been published on the subject (in 1977 in Australia\footnote{\textsuperscript{49}} and in 1979 in New Zealand).

Legislation in certain Australian States specifically exempts chiropractors from the physicians' monopoly of health care. For example, the Medical Act 1894-1968 of Western Australia prohibits persons other than medical practitioners from practising medicine or surgery, but continues: "provided that this paragraph shall not apply to a person practising as a ... chiropractor who gives ... chiropractic advice or service". In South Australia, chiropractic is the subject of specific legislation (the Chiropractors Act, 1949).\footnote{\textsuperscript{50}} There is also separate legislation governing chiropractic in New Zealand.\footnote{\textsuperscript{51}}

The fact that chiropractic and osteopathy originated in the United States in the second half of the 19th century and became popular there...
registered under this Act may practise as chiropractors or osteopaths or use such titles. They may not prescribe or administer drugs, use anaesthetics, or practise surgery or midwifery. Unauthorized practice constitutes a criminal offence. The requirements for registration include passing an examination following completion of a four-year course specified in the Regulations (the educational and examination requirements are somewhat more demanding for osteopathy than for chiropractic). While the definition of osteopathy in the Regulations is very vague ("treatment by ... methods taught at colleges of osteopathy and approved by the Board"), the definition of chiropractic is more specific:

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The fact that chiropractic and osteopathy originated in the United States in the second half of the 19th century and became popular there may at least partially explain the greater tendency in North America to tolerate these techniques as forms of alternative medicine. Efforts to legalize such professions in the developed countries sometimes also reflect the notion that persons should be entitled to determine the kind of treatment they undergo. The long period of education and training which is necessary if the health of patients is to be safeguarded may justify the monopoly sought by manipulative therapists once the profession has been legally recognized (there are also, of course, economic advantages in a monopoly).

In many States of the USA (where several million people use the services of chiropractors), chiropractic is covered by Medicaid and other social security programmes and by private health insurance schemes.

In 1975, the Danish Ministry of Social Affairs decided that the public health insurance scheme would provide coverage of up to four courses of chiropractic treatment and one X-ray examination within 12 calendar months by chiropractors recognized by the Danish Chiropractic Council. However, if the patient is not referred by a physician, the patient's general practitioner or the physician consulted by the patient must be notified by the chiropractor regarding the diagnosis and treatment. \[^{52}\]

Some developing countries, particularly those formerly administered by the United Kingdom, have enacted legislation specifically recognizing manipulative therapy. Thus, in Fiji, the Medical and Dental Practitioners Act, 1963 empowered the Minister of Health to issue regulations governing chiropractic, acupuncture, and chiropody, and such regulations were issued in 1976. \[^{53}\] The Medical Service (Amendment) Act, 1979 of Guyana \[^{54}\] legalized the practice of osteopathy by registered osteopaths. Chiropractic and osteopathy are recognized in Lesotho under the Natural Therapeutic Practitioners Act 1976 (see p. 301), and in Swaziland chiropractic is recognized under the Control of Natural Therapeutic Practitioners Regulations, 1978 (see p. 301). More recently the Natural Therapists Act, 1981 of Zimbabwe regulated the organization and registration of, inter alia, osteopaths (see p. 301).

**Homoeopathy**

In most legislation dealing with homoeopathy, a definition, or a distinction between homoeopathic treatment and orthodox medicine, is not provided. The concept of homoeopathy is generally assumed to be understood as a monopoly, and reference is made such as "treatment with potentised or herbal remedies dispensed in accordance with the principles of homoeopathy" (the Natural Therapists Act, 1981 of Zimbabwe) or simply "the system of medicine established by Dr Hahnemann" (the Homoeopathy Act, No. 7 of 1970 of Sri Lanka).

There are considerable differences in the legal and professional status of homoeopaths as between the developed countries, the countries of the Indian subcontinent, and the countries of Southern Africa. From the point of view of the regulation of homoeopathy, two basic questions arise: (a) has this system been recognized as a method...
which may lawfully be used in orthodox medicine; and (b) should persons other than formally trained physicians be authorized to practise homoeopathy and, if so, under what conditions? Another important issue is the regulation of homoeopathic drugs.

Policies on the recognition of homoeopathy within orthodox medicine appear to differ between the Western countries and the socialist countries of Eastern Europe.

In most Western countries, it is unusual for legislation to stipulate that certain methods of medical treatment are acceptable or unacceptable (exceptionally, a certain method, or more often the use of certain drugs, may be prohibited). In general, the question of whether a certain method of treatment may be used by physicians is a question of lex artis, i.e. of the accepted state of medical science. Even the self-evident duty of physicians to act lege artis, although generally accepted, has been explicitly laid down by law only in a few Western countries, such as Austria and Sweden. Where necessary, the state of lex artis is presented to the courts by expert witnesses or in the form of expert opinions by scientific bodies. It is generally recognized that physicians are obliged to keep themselves informed of developments in medical science, but it is left to their own judgement to decide which treatment is appropriate in each specific case. Despite continuing controversy over the medical value of homoeopathic methods (ranging from the statement by an author in the Federal Republic of Germany that “the allopathic and homoeopathic methods coexist on an equal footing”152 to the conclusion by an Australian Parliamentary Commission in 1977 that “the practice of homoeopathy cannot be supported by any scientific evidence”), physicians in Western countries may generally use homoeopathic methods if they wish.

Savatier’s formulation of the issue, expressed nearly 30 years ago, may still be of interest: 

... the general principle that the courts may not resolve medical controversies must be respected. It would not appear that the courts can condemn homoeopathic doctrines that attach part of the value of the medicaments to the personal influence of the person preparing them; ... and it is doubtful that they are entitled to affirm that another treatment would have been more effective than a homoeopathic treatment, in such a way that the homoeopathic physician would be guilty of malpractice by not having applied that [other] treatment.

In some of the larger Western European countries there are several hundred homoeopathic physicians, the number being as high as 1000 in the Federal Republic of Germany (homoeopathy originated in Germany). According to recommendations issued by the Conference of Physicians in the Federal Republic in 1976, physicians may even claim specialization in homoeopathy if they undergo the following further training: (1)(a) not less than one-and-a-half years’ theoretical or practical training in homoeopathic treatment under the supervision of a recognized homoeopathic physician, or (b) six months’ training in a hospital recognized as specializing in homoeopathy; and (2) attendance at three recognized courses of further training or a recognized three-month course in homoeopathic therapy (information on which courses are recognized is provided by the Association of Physicians).155 The Association of Physicians of Berlin (West) has not, however, included homoeopathy in its rules on the further training of physicians.156

In the United Kingdom, the Faculty of Homoeopathy was established in 1950. France provides a university course in homoeopathy for medical students, but makes no provision for specialization in this subject.

Various countries go some way towards statutory recognition of homoeopathy by authorizing homoeopathic pharmacopoeias. The authority of some of the best known of these is reflected in the fact that they are sometimes accepted for official use in other countries. Thus, before the official Homoeopathic Code of Brazil was issued (in 1972), a Decree dated 1965157 required Brazilian pharmacies to use the United States and French homoeopathic pharmacopoeias. In India, the Drugs and Cosmetic Rules, 1945 referred to the “homoeopathic pharmacopoeias of the United States or the United Kingdom”. Reference is made to the registration of homoeopathic medicaments in the 1976 Medicaments Law of the Federal Republic of Germany.158

A more sceptical attitude towards homoeopathy is found in the legislation of the socialist countries of Eastern Europe. More often than in Western countries, the duty of physicians to proceed lege artis in the treatment of their patients is expressly laid down by law. Section 34 of the Fundamental Principles of the Health Legislation of the Union of Soviet Socialist Republics and of the Union Republics goes so far as to require physicians to use diagnostic, prophylactic, and therapeutic methods, and pharmaceutical products, authorized by the Ministry of Health (a similar provision exists in the Bulgarian Law on public health); neither homoeopathic methods of treatment nor homoeopathic medicaments have been authorized. In Hungary, as a rule, the freedom of the physician to determine treatment is recognized, but homoeopathic methods are considered unscientific. Similarly, in Czechoslovakia, the 1966 Law on the protection of public health159 prescribes that medical treatment must be provided in accordance with the present state of medical science, although as a rule the use of certain methods is not subject to authorization by the Ministry of Health; however, it may be significant that, whereas the application of chiropractic and acupuncture by specialized physicians has been regulated, no such provision has been made for homoeopathy. Instructions No. 22 of 1975 on the prescribing and dispensing of medicaments160 stipulate that homoeopathic medicaments, unlike most medicaments in Czechoslovakia, may not be prescribed or dispensed free of charge.

The situation in the German Democratic Republic is somewhat more complicated owing to the persistence of earlier traditions. The question once again is whether homoeopathy may be considered a scientific method, since the Framework Rules on hospitals161 require high-

International Digest of Health Legislation, 1985, 36 (2)
which may lawfully be used in orthodox medicine; and (b) should persons other than formally trained physicians be permitted to practice homoeopathy and, if so, under what conditions? Another important issue is the regulation of homoeopathic drugs.

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level prophylaxis, diagnosis, and therapy to be provided in accordance with the requirements of medical science. This question is not answered either directly or indirectly by the law. However, evidence of the views prevailing in the German Democratic Republic is provided in the following conclusion by a leading representative of forensic medicine, referring to the opinions expressed in a 1958 statement by the Faculty of Medicine of the Humboldt University: “In the light of scientific knowledge, homoeopathy cannot be used for the treatment of serious illnesses, particularly organic ones”. No homoeopathic pharmacopoeia is recognized in the GDR. Formulas as to standard homoeopathic procedures are incorporated in the Standard Formulas [Standardrezepturen], which appear as an Annex to the 1977 Drugs List [Arzneimittelverzeichnis].

The situation regarding the practice of homoeopathy by non­physicians in the countries of Western Europe with a “tolerant” system can be seen from what has been indicated above. In the United Kingdom and some countries of Scandinavia, any person may practise healing except with regard to certain diseases, prescribing of drugs, etc. In the Federal Republic of Germany (and still to a limited extent in the German Democratic Republic), only duly licensed lay health practitioners may practise as homoeopathic healers without formal training. In the developing world, two distinct trends can be identified in two major regions.

On the Indian subcontinent, the profession of homoeopathic medicine (together with modern medicine and Ayurvedic and Unani medicine) has become a part of established medicine. The following statement by Leslie is of assistance in appreciating the special position of homoeopathic medicine in this region:

Homoeopathic medicine is... widely practised in India, and for legislative purposes it is often associated with the indigenous systems. Dr S. M. Bhardwaj has described the process that he calls “the naturalization of homoeopathy” in India during the nineteenth century. He argues that homoeopathy first appealed to a new urban elite of a “modern” system. Its basic ideas were readily understandable and were soon made accessible in Indian languages to “even moderately literate people”... unlike the advocates of cosmopolitan medicine,... the advocates of homoeopathy were sympathetic to indigenous medical practices and tried to show that the principles of Ayurveda were consistent with homoeopathy... most registered homoeopathic practitioners are registered jointly with practitioners of Ayurvedic and Unani medicine, although separate state boards of homoeopathic medicine are now being formed. The fourth 5-year plan allocated 15 million rupees for this purpose, and 47 institutions offered homoeopathic treatment in 1972.

In India, the Homoeopathy Central Council Act of 19738 provided for the registration of homoeopaths in State registers, and established a Central Council for Homoeopathy. “Medical institutions”, including universities that possess a faculty of homoeopathy or provide teaching in homoeopathy, may grant degrees, diplomas, or licences. The Central Council is empowered to prescribe standards of professional conduct and a code of ethics for homoeopaths. The Council may also prescribe minimum educational standards for the granting of qualifications by medical institutions. Nevertheless, in Leslie’s view (referring to the period preceding 1974), “training is often acquired through correspondence courses that thinly disguise the selling of credentials”. The Drugs and Cosmetics Act, 1940, as amended,14 and the Drugs and Cosmetics Rules, 1945, as amended,15 include detailed provisions regarding the importation into, and the manufacture and distribution of, homoeopathic medicines in India.

In Pakistan, a 1962 Ordinance prohibited “persons pursuing the homoeopathic system of medicine” from using the title of “doctor” unless they were registered medical practitioners. Only a few years later, in 1965, the Unani, Ayurvedic and Homoeopathic Practitioners Act introduced the title of “homoeopathic doctor” for registered homoeopaths, although the use of analogous titles was forbidden to practitioners of the Ayurvedic and Unani systems of medicine. Under this Act, courses in homoeopathy provided by recognized institutions must be of four years’ duration, culminating in a qualifying examination. Persons who have passed this examination, persons holding qualifications from an approved homoeopathic institution, and certain practitioners of long standing “possessing the requisite knowledge and skill” are eligible for registration as homoeopathic doctors. A Board of Homoeopathic Systems of Medicine was established in order, inter alia, to maintain adequate standards of efficiency in recognized institutions and to make arrangements for the registration of duly qualified persons.

The legislation referred to above was also applicable in what was then known as East Pakistan (now Bangladesh).

In Sri Lanka, a Homoeopathy Act was enacted in 1970.14 This established a Homoeopathic Council to regulate and control the practice of homoeopathic medicine, to maintain a Homoeopathic Medical College, etc. This statute exempted persons practising homoeopathic medicine, pharmacy, or nursing from the provisions of the Medical Ordinance, and empowered the competent Minister to make regulations for the control of professional conduct and other matters. In particular, the Council is empowered to register homoeopathic medical practitioners, to recognize homoeopathic institutions, to hold examinations and award degrees in homoeopathic medicine, and to arrange for postgraduate study in homoeopathy. The Council also maintains a register of homoeopathic practitioners. With some exceptions, qualification following a course of study of not less than four years’ duration is a prerequisite for registration. Only registered practitioners may practise homoeopathy for gain and use the title “registered homoeopathic practitioner”. Such practitioners are also entitled, inter alia: (1) to issue certificates or other documents required to be issued by medical practitioners; (2) to hold posts as medical officers in public
level prophylaxis, diagnosis, and therapy to be provided in accordance with the requirements of medical science. This question is not answered either directly or indirectly by the law. However, evidence of the views prevailing in the German Democratic Republic is provided in the following conclusion by a leading representative of forensic medicine, referring to the opinions expressed in a 1958 statement by the Faculty of Medicine of the Humboldt University: “In the light of scientific knowledge, homoeopathy cannot be used for the treatment of serious illnesses, particularly organic ones”. No homoeopathic pharmacopoeia is recognized in the GDR. Formulas as to standard homoeopathic procedures are incorporated in the Standard Formulas [Standardrezepturen], which appear as an Annex to the 1977 Drugs List [Arzneimittelverzeichnis].

The situation regarding the practice of homoeopathy by non­physicians in the countries of Western Europe with a “tolerant” system can be seen from what has been indicated above. In the United Kingdom and some countries of Scandinavia, any person may practise healing except with regard to certain diseases, prescribing of drugs, etc. In the Federal Republic of Germany (and still to a limited extent in the German Democratic Republic), only duly licensed lay health practitioners may practise as homoeopathic healers without formal training. In the developing world, two distinct trends can be identified in two major regions.

On the Indian subcontinent, the profession of homoeopathic medicine (together with modern medicine and Ayurvedic and Unani medicine) has become a part of established medicine. The following statement by Leslie is of assistance in appreciating the special position of homoeopathic medicine in this region:

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medical institutions; and (3) to sign birth or death certificates, medical certificates, and certificates of physical fitness.

To sum up, the legal position of homoeopaths under the "inclusive" health care systems of the Indian subcontinent has been elevated — at least in theory — to a professional level similar to that of a medical practitioner qualified by studies at a university-level institution.

During the 1970s, homoeopathy came to be legally regulated in four countries of Southern Africa, but its status there is not comparable with that in the Indian subcontinent. The legislation concerned is as follows: in Lesotho, the Natural Therapeutic Practitioners Act 1976 ("natural therapist" means providing health services other than those normally recognized by the medical profession and includes "methods commonly used by homoeopaths, naturopaths, osteopaths, chiropractors and acupuncturists"); in South Africa, the Homoeopaths, Naturopaths, Osteopaths and Herbalists Act, 1974; in Swaziland, the Control of Natural Therapeutic Practitioners Regulations, 1978; and in Zimbabwe, the Natural Therapists Act, 1981. The act prescribes that registration may be required to recommend treatment by orthodox medicine if the patient’s condition indicates that his life may be in danger (this, for instance, is the legal position in the Federal Republic of Germany). A related problem is the regulation of cooperation between traditional healers and modern physicians and health institutions.

295. Such a prohibition is conceived as a preventive measure to limit health hazards rather than as a penalty.

4. LEGISLATIVE SAFEGUARDS AGAINST HEALTH HAZARDS ARISING FROM LIBERALIZATION OF THE EXCLUSIVE SYSTEMS OF HEALTH CARE

Since the needs of a large part of the world’s population cannot be met through the existing system of formalized health care — at least during this generation — liberalization of the practice of traditional healers and other unorthodox health care providers becomes a logical alternative. This means, of course, that certain medical services would be provided by people lacking the education, training, and organization that characterize modern, scientific health systems. Accordingly, two important problems arise whenever liberalization of an exclusive system of health care is considered:

— the limits to be imposed on the intended freedom of treatment; and
— the workable legal safeguards that can be introduced to protect the population against charlatanism and hazardous incompetence.

In order to evaluate past experience with legislation, a brief survey of the attempts to establish such limits and safeguards may be useful.

Limits on freedom of treatment

Under some tolerant systems, certain categories of health care are restricted to physicians, e.g. in the Federal Republic of Germany, the United Kingdom, and Southern African countries. Non-physicians are prohibited from inciting patients to abstain from treatment by modern scientific methods, e.g. in certain Southern African countries. Traditional or "alternative" practitioners may also be required to recommend treatment by orthodox medicine if the patient’s condition indicates that his life may be in danger (this, for instance, is the legal position in the Federal Republic of Germany). A related problem is the regulation of cooperation between traditional healers and modern physicians and health institutions.

Even where general freedom of treatment exists, persons may be prohibited from providing treatment if they have displayed incompetence that may endanger life or health (see the Swedish provisions to control "charlatanism constituting a danger to health", p. 293). Such a prohibition is conceived as a preventive measure to limit health hazards rather than as a penalty.

In countries where the needs of the population can be satisfied by the established system of modern scientific medicine, state funding of...
medical institutions; and (3) to sign birth or death certificates, medical certificates, and certificates of physical fitness.

To sum up, the legal position of homoeopaths under the "inclusive" health care systems of the Indian subcontinent has been elevated — at least in theory — to a professional level similar to that of a medical practitioner qualified by studies at a university-level institution.

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The laws of Lesotho, South Africa, and Swaziland include almost identical lists of procedures that registered homoeopaths may not perform (on pain of committing an offence). These lists include surgery, midwifery, "internal examination", administration of intravenous injections, and treatment of cancer. Under the laws of these three countries, a homoeopath is prohibited from claiming to be a medical practitioner or from "leading persons to infer that he possesses the qualification of a medical practitioner". There is also an express prohibition against improperly influencing a person to abstain from treatment by a physician or other health professional. The 1981 Zimbabwe legislation does not include such prohibitions.

From the above summary, it will be clear that homoeopaths, as seen by the legislatures of these four Southern African countries, are assumed to be considerably less qualified than homoeopathic practitioners in the Indian subcontinent. Except perhaps in Zimbabwe, the only formal safeguard regarding the competence of the candidate is

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In countries where the needs of the population can be satisfied by the established system of modern scientific medicine, state funding of
health care (through a national health service or public health insurance) may be restricted to care provided by orthodox physicians and health institutions. This is the legal situation in the United Kingdom and in the Federal Republic of Germany. So long as certain persons are deemed to provide a higher level of health care owing to their superior education, training, etc., the State is justified in paying only for health care provided by such persons. Such an arrangement should not be held to foster inequality (provided, of course, that all persons do in fact have access to health care under the modern system).

Legal safeguards against incompetence and charlatanism

Where an unorthodox profession is recognized and regulated, the relevant legislation requires registration, and in most cases licensing, of the practitioners concerned. This approach is widespread in both developed and developing countries (with reference to chiropractors, acupuncturists, and other health professionals in the USA and Canada, practitioners of Ayurveda, Unani, and homeopathy in the Indian subcontinent, and various kinds of traditional practitioners in the Southern African countries). Unregistered persons are prohibited from practising. In addition, provision is usually made for the establishment of a body (council, board, etc.) with certain organizational and disciplinary powers. Some countries lay down regulating provisions in varying degrees of detail regarding professional practice, codes of ethics, etc., which may be enforced by such bodies. Experience shows, however, that such representative bodies may tend to defend the economic interests of practitioners uncritically, and to promote their exclusive rights and monopolies rather than to watch efficiently over the professional standards and disciplines of their members. The law should therefore provide for supervision of such "peer" bodies by a higher state authority. The rationale behind such organization of licensed practice of a health profession is to ensure a certain standard of health care by preventing unregistered persons from practising. Such arrangements vary with regard to the qualification requirements for registration and licensing. A certain level of education and training may be required (in the case of institutionalized professions such as Ayurveda, even university-level education may be necessary), or a certain period of practice, the passing of examinations, or sometimes simply recommendation by an organization (e.g. in South Africa). Under the Natural Therapists Act, 1981 of Zimbabwe, the applicant must "establish to the satisfaction of the Council" that his training and experience qualify him to practise. Because another purpose of legislation of this kind is to grant legal recognition to persons already practising the professions in question, there is usually a provision conferring entitlement to registration and licensing upon all persons who were practising before the legislation came into force. These "grandfather clauses" may be conditional upon some minimum proof of ability to provide the health care in question but, in general, they make it more difficult to ensure a satisfactory level of skill among the profession as a whole.

The unique legislative provisions concerning lay health practitioners in the Federal Republic of Germany and the German Democratic Republic have been described above. In contrast to the regulation of unorthodox health professions in other countries, the Heilpraktiker licence authorizes holders to provide most kinds of health care (but with specified exceptions). The safeguards against incompetence in this system are generally considered weak (see p. 293). The arrangement that has developed in Niger (see p. 298), whereby applicants for licences to practise traditional medicine must undertake a short period of training in a medical institution, may be worth consideration by legislators.

It is noteworthy that legislation legalizing and organizing unorthodox health professions usually makes no provision for the further training of practitioners. A certain number of statutes expressly prohibit traditional practitioners from claiming to be medical practitioners (i.e. physicians), or using titles or descriptions implying that they possess such qualifications. Breach of professional duties by unorthodox practitioners may result in disciplinary measures, mostly imposed by the representative bodies of the professions concerned. Legislation frequently provides for criminal penalties (typically fines, a short term of imprisonment, or both, even for minor breaches). Criminal penalties are also laid down in cases of unauthorized practice by unregistered or unlicensed persons.

Such overextension of criminal law conflicts with one of its essential principles, namely that penalties under the criminal law (as distinguished from fines and disciplinary measures imposed by professional bodies) from its effectiveness the criminal law in the field of traditional medicine is frequently minimal: any enforcement of the law may well be arbitrary. Indeed, it is easy to imagine the difficulty of attempting to prosecute, try, and sentence for the offence of unregistered practice a traditional healer who may enjoy a high reputation in his community. In most countries (especially in States with a civil law legal system), sanctions by the administrative authorities rather than the full force of the criminal law would be a more appropriate way of dealing with breach of their legal duties by unorthodox practitioners.

5. PROBLEMS CONNECTED WITH BELIEF IN SUPERNATURAL FORCES AND WITCHCRAFT

A delicate problem for legislation concerned with traditional medicine is the attitude to supernatural elements in traditional healing, and in particular how witchcraft should be treated in legislation. As the definition quoted at p. 286 shows, "the religious background as well

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health care (through a national health service or public health insurance) may be restricted to care provided by orthodox physicians and health institutions. This is the legal situation in the United Kingdom and in the Federal Republic of Germany. So long as certain persons are deemed to provide a higher level of health care owing to their superior education, training, etc., the State is justified in paying only for health care provided by such persons. Such an arrangement should not be held to prevent access to health care under the modern system.

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as ... beliefs that are prevalent in the community" may form an integral part of the healing processes employed by many traditional healers. As such beliefs may be firmly rooted and widespread in the population it is difficult to eliminate them from traditional medicine. Indeed, they may be used to obtain beneficial "placebo" or psychotherapeutic effects. On the other hand, the opportunities for fraud, as well as the serious dangers involved in witchcraft, are evident. In order to appreciate the role played by the supernatural in certain forms of traditional medicine reference may be made to the description of traditional medicine and traditional beliefs in Guyana (a country with several ethnic cultures), presented by Mootoo at the Sixth World Congress on Medical Law in Ghent in 1982.168 Nevertheless, it should be borne in mind that fraud is not necessarily restricted solely to psychic methods: it may equally arise in connection with the administration of herbal or other medicines. That is probably why legislation authorizing purely physical forms of traditional therapy, and specifically prohibiting methods based on the supernatural, is to be found only sporadically. An example of this is the legislation enacted for the Belgian Congo (now Zaire) permitting the practice of traditional medicine only insofar as it consisted of the "treatment by administering drugs".

Some degree of legislative control of witchcraft is necessary, and it goes without saying that intervention in this field is extremely difficult. Two particular questions arise in this connection: what degree of risk to society justifies legal prohibitions and sanctions; and what kind of legislative regulation is workable in particular circumstances. Legislation dealing with witchcraft and belief in the supernatural, often originating in the colonial era, follows two broad patterns. Some, such as the Malawi Witchcraft Act of 1911, the Tanganyikan Witchcraft Ordinance of 1928, and the Ugandan Act for the prevention of witchcraft of 1957, makes the practice of witchcraft or the claim of supernatural powers an offence in itself irrespective of the purpose for which such powers may be exercised. Other legislation, such as the Penal Code of the Belgian Congo, which is still in force in Zaire, and the Kenyan Witchcraft Ordinance of 1925, renders witchcraft an offence only in conjunction with the use, or threatened use, of the powers for a harmful purpose, for example "with intent to injure", or "for the purpose of causing fear", etc. The excessively general prohibition involved in the first type of legislation renders it unenforceable and indeed makes the administration of justice arbitrary if not discriminatory. Legislation of the second type may be necessary, depending on the degree of danger involved in the customs or beliefs concerned.

Mootoo’s report demonstrates the widespread belief in witchcraft as a source of illness. A long series of reported criminal cases from the former British colonies in East Africa show how often and how typically the use of purported supernatural powers by witch-hunters or witchdoctors could lead to the murder of suspected witches, or indeed become a means of extortion. Consequently, legislation, such as the Kenyan Witchcraft Ordinance, also provides for the punishment of anyone who “accuses or threatens to accuse any person with being a witch”.

Somewhat similar distinctions between harmless and possibly harmful customs, rights, and beliefs must be made by health administrators in considering the methods of healing entailing supernatural forces that are acceptable within any framework of cooperation with practitioners of traditional medicine.

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9. Order of 6 January 1962 prescribing the list of medical procedures that may be performed only by physicians or that may also be performed by allied health profession or by non-medically qualified directors of clinical laboratories (Journal officiel de la République algérienne démocratique et populaire, 11, 12. Federal Law No. 50 of 18 March 1964.


12. WARREN, D. M. & TREGONING, M. A., supra ref. 22, at p. 11.

13. Decision of July 1930 (RGSt. 64, 263).


25. LISTER, J., supra ref. 36, at p. 1526.


29. UNSCHULD, P. U., supra ref. 29, at p. 16.

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11. Corpus Juris Secundum, supra ref. 6, at p. 828.

12. Federal Law No. 50 of 18 March 1964. IDHL, 18(4): 735-765 (1964), at p. 735. Sec. 1G(3) prescribes that "the practice of medicine includes all activities based on medico-scientific knowledge carried out directly or indirectly on human beings...". Sec. 1a(1) lays down that "the independent practice of medicine shall be the exclusive right of general practitioners and specialists".

13. SAVATIER, R. et al., supra ref. 8, at p. 44.


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*This abbreviation is used throughout this list for International Digest of Health Legislation.*


44. Traditional medicine in Zaire: present and potential contribution to the health services, supra ref. 42, at p. 3.

45. See, for example, the special issue of *Social science & medicine* (1982, 16, No. 21) devoted to "Utilization of indigenous healers in national health systems".


56. Personal communication dated 25 August 1982 from Dr Hamadou Ousseini, Chief Physician of the Niamey Hospital, Niger.


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108. Act No. 74 of 1953, as amended.


113. Ibid., pp. 330-331.


International Digest of Health Legislation, 1985, 36 (2)
89. IDHL, 18(2): 428 (1967).
98. Act No. 74 of 1953, as amended.
100. Act No. 48 of 1962.
110. ROEMER, M. L., supra ref. 22, at p. 73.
137. West's Annotated Californian Codes. Chapter 12 (Acupuncture), consisting of Sections 4925-4979, cited as the "Acupuncture Certification Act" of Vol. 3A (Business and Professions Code).
139. SCHWARTZ, R., supra ref. 134, at p. 7.
140. SAVATIER, R. et aI., supra ref. 8, at p. 48.
142. Corpus Juris Secundum, supra ref. 6, at pp. 828 et seq.
146. Revised Statutes of Ontario 1970, Chapter 137. Regulations under the Drugless Practitioners Act Nos. 228 (Chiropractors), 229 (Classifications), 230 (General), 231 (Masseurs), 232 (Osteopaths), and 233 (Physiotherapists).
151. SAVATIER, R. et aI., supra ref. 8, at pp. 237-258.
152. NARR, H., supra ref. 30, at p. 380.
153. NARR, H., supra ref. 30, at p. 212.
161. UNSCHULD, P., supra ref. 29, at p. 24.
162. LESLIE, C. Pluralism and integration in Indian and Chinese medical systems, supra ref. 79, at pp. 401, 404.
164. West's Annotated Californian Codes. supra ref. 137, at Section 6946.5.
137. West's Annotated Californian Codes. Chapter 12 (Acupuncture), consisting of Sections 4925-4979, cited as the "Acupuncture Certification Act" of Vol. 3A (Business and Professions Code).
139. SCHWARTZ, R., supra ref. 134, at p. 7.
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146. Revised Statutes of Ontario 1970, Chapter 137. Regulations under the Drugless Practitioners Act Nos. 228 (Chiropractors), 229 (Classification), 230 (General), 231 (Masseurs), 232 (Osteopaths), and 233 (Physiotherapists).
150. DENMARK, MINISTRY OF SOCIAL AFFAIRS. Notification of 7 January 1975 on contributions for chiropractic treatment under the Health Insurance Law.
154. SAVATIER, R. et al., supra ref. 8, at pp. 237-258.
155. NARR, H., supra ref. 30, at p. 380.
156. NARR, H., supra ref. 30, at p. 212.