The subject of self-care is now increasingly a topic of discussion in the industrialized countries. Reflecting WHO's interest in the subject, a round table dealing with some key issues appears in the current issue of the new WHO journal, World Health Forum (1981, Vol. 2, No. 2). It comprises two articles, "Self-care in health: potentials and pitfalls" (by L. S. Levin) and "Self-help groups in primary health care" (by D. Robinson), followed by critical contributions from eight experts in primary health care.

The starting-point for the present symposium was an article by L. B. Andrews and L. S. Levin, which originally appeared in the United States journal Social Policy. Contributors from seven European countries were then invited to submit articles examining the issues raised by Andrews and Levin in the light of experience in their own countries.

The countries and contributors are as follows: Denmark: Mr J. Nehm (Head, Legal Section, Department of Education, National Board of Health, Copenhagen); England and Wales: Dr J. D. Williamson (general medical practitioner, Barnsley, South Yorkshire); Federal Republic of Germany: Professor C. von Ferber (Director, Institute of Medical Sociology, Dusseldorf); Netherlands: Dr J. C. Hessing-Wagner (a sociologist on the staff of the Department for Long-term Planning of the Ministry of Public Health and Environmental Hygiene) and Dr M. van Doorn-de Leeuw (a lawyer currently preparing a comprehensive study of the relationship between health care and the law); Portugal: Mr F. Afonso e Cunha (Legal Officer, Lisbon Health Department) and Dr C. T. Sakellarides (Public Health Officer and Instructor, National School of Public Health, Lisbon); Sweden: Mr K. G. Wilow (Legal Adviser to the National Board of Health and Welfare, Stockholm); and Switzerland: Professor T. Abelin (Professor and Head of the Department of Social and Preventive Medicine, University of Berne). The contributions made by the above persons are gratefully acknowledged.

The editors of the Digest also wish to thank Ms B. Swartz, Associate Professor of Clinical Law, New York University School of Law, New York, for her work in identifying the contributors, in consultation with the competent national health authorities.

The views expressed in these articles do not necessarily reflect the views of the contributors' national governments or of WHO.
Self-care and the law

Lori B. Andrews\(^b\) and Lowell S. Levin\(^c\)

Based on the assumption that most health and medical care is provided by specially trained and licensed health care practitioners, it has been customary to view the history of medicine and medical care as synonymous with the history of the health professions. When we speak of the health care system, we refer to a complex of professional resources, and when we speak of health care workers, we are again referring to professional categories. When health planning strategies are being proposed, a differentiation is made between health care providers and consumers. Governmental agencies and insurance companies define health care costs as expenditures for professional services and related technical accessories. The construction of health and medical affairs as a universe of professional resources and activities confines both the definition of society's health problems and their solutions to professional criteria and the manipulation of professional institutions and resources such as reforms in recruitment, education, deployment, efficiency, quality control, and payment for services.\(^1\) It overlooks the current preferences of people and potential nonprofessional health resources.

Laws governing the delivery of health care by and large reflect the same assumptions. The 51 medical practice acts (one for each state and the District of Columbia) define the practice of medicine\(^2\) and then limit the practice to licensed individuals. As currently drafted, the statutes' broad reach could conceivably encompass anyone who treats self or family. For example, under the Virginia statute, it is a crime for a layperson to engage in "the prevention, diagnosis, and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or methods."\(^3\) Other medical practice acts describe in more detail the methods of health care which are prohibited. In California, "diagnosis" includes the simple taking of blood pressure even if it is done gratuitously.\(^4\) Delaware law prohibits the selling, giving, suggesting, recommending, or prescribing of any drug, surgery, medicine, appliance, or other agent for the prevention, cure, or

\(^a\) This article was originally published in Social Policy, 1979, 9, No. 4, pp. 44-49. It is reproduced here with the kind permission of the publishers, Social Policy Corporation, New York, NY 10036, USA; copyright 1979 by Social Policy Corporation. — ED.

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relief of any ailment or disease of the mind and body or any symptom thereof.\textsuperscript{5} States like Maine, Michigan, and South Carolina go even further by prohibiting treatment which consists of merely attending or advising the patient.\textsuperscript{6} Sixteen statutes cover not only treatment itself, but also the recommendation of treatment.\textsuperscript{7}

The sweeping language of the practice acts gives little hint as to the parameters of liability. A prohibition against the treatment of a physical condition by attendance might exclude fathers from the delivery room. Conceivably, a law against giving any drug or other agent to a person for the relief of any ailment could cover a parent's administering cough syrup to a child. Suggesting surgery for a deformity might extend to advising a friend to consider cosmetic surgery for a misshapen nose. Statutory language about prevention would seem to classify a newspaper article advising people to get swine flu shots or a book on nutrition which tells people to stop eating eggs in order to avoid heart attacks, as the unauthorized practice of medicine.

Although it may seem contrary to common sense to consider these hypothetical situations as the unauthorized practice of medicine, the medical practice acts have been used in suits against a varied range of people: masseuses,\textsuperscript{8} hypnotists,\textsuperscript{9} abortion counselors,\textsuperscript{10} the author of the book \textit{One Answer to Cancer},\textsuperscript{11} a feminist who gave a woman a yogurt treatment for a vaginal infection,\textsuperscript{12} and city officials in charge of fluoridating a town's water.\textsuperscript{13} Even when, as in the case of the yogurt or fluoridation treatments, the unauthorized practice claim is rejected, such suits harm the public by keeping from it potential health care benefits. The equipment and records of the Los Angeles Feminist Women's Health Center were impounded by police for over a year in the process of a suit which resulted in the acquittal of the staff member who recommended the yogurt treatment.\textsuperscript{14}

Courts have held that it is immaterial whether the advice or treatment is offered without charge\textsuperscript{15} and that a single incident is sufficient to constitute the "practice" of medicine.\textsuperscript{16} It makes no difference in a prosecution whether the person was in fact helped by the advice or treatment.\textsuperscript{17} The types of ailments and conditions to which the acts apply include nervousness,\textsuperscript{18} obesity,\textsuperscript{19} and pregnancy.\textsuperscript{20} Treatments can deal with diet, exercise, and mode of living.\textsuperscript{21}

\textit{The growth of self-care}

In limiting to licensed professionals the right to provide health care, the medical practice acts overlook the option of self-care. It has been estimated that self-care activities could account for as much as 75 percent of all health care.\textsuperscript{22} One observer noted that without self-care "the professional health care system would be swamped."\textsuperscript{23} Furthermore the modest research available suggests that the vast proportion of self-initiated health care is both safe and relevant.\textsuperscript{24} We do not, in fact, know as much about this ubiquitous and pervasive lay health resource as we do about the professional resource, reflecting the bias in perspective
noted previously. Self-care was frequently denigrated as "rampant empiricism"25 or appraised as a shrinking artifact of a bygone era. It was not until this decade that serious and less judgmental examinations of nonprofessional resources in health care were begun.26

Recent changes in the patterns of disease and the technologies of treatment encourage lay people to engage in medical practices which were once the realm of the medical professional. Perhaps the most powerful influence came as a result of the shift in the morbidity rate during the past four decades from 30 percent of all diseases being chronic to the present 80 percent. There are not enough licensed health care professionals to deal with the over 50 percent of the civilian population in the United States reported to have one or more chronic diseases. Moreover, people suffering from chronic diseases like diabetes and hypertension cannot sit back passively and be ministered to by health care professionals; for both economic and practical reasons, they must learn to follow health routines regarding diet and medication. In addition to dramatizing the logistical and economic importance of people learning the techniques of chronic disease management, the move from diseases amenable to cure to those requiring long-term care has stimulated the growth of mutual aid groups. There are now over 500,000 mutual aid groups, such as Mended Hearts, Emphysema Anonymous, and the International Association of Laryngectomies, to provide skills and support in coping with disabilities and in reducing their physical, psychosocial, and economic consequences.27

Self-care and mutual aid goes beyond the chronic disease situation, however. Popular interest in developing self-care skills is amply demonstrated in the burgeoning literature which provides detailed and explicit instruction on a vast range of health and medical care subjects. In addition, organized programs to educate people in self-care have proliferated since 1970. There appears to be a wide diversity in sponsorship, characteristics of participants, objectives, conceptual orientation (allopathic vs. nonallopathic), content range, educational methods, evaluation, and funding. Two basic models, however, seem to be visible. One is a pre-designed self-care program modeled after Keith Sehnert's "Health Activation Program."28 This program emphasizes health promotion, disease prevention, health monitoring, medication control, minor illness and injury control, and the effective use of the professional care system. A second educational model relies on client-determined content, methods, and outcome criteria. This latter model, developed at the Yale Department of Epidemiology and Public Health, limits content only in terms of the clients' interests and willingness to invest the necessary time and effort in acquiring the skills.

As a result of such programs, lay people have found that they are capable of learning and practicing organization and personal health skills previously within the domain of the certified expert. Staffs of some women's free clinics have undertaken to teach medical skills which bypass professional ministrations, demonstrating the effective reality of lay self-care.29 For example, the Los Angeles Feminist Women's Health
Center sponsors meetings where women exchange information about dealing with vaginal infections and learn to examine themselves and each other. A Washington clinic teaches women to do laboratory blood analysis.

In addition to the change in disease patterns and the popularity of "do-it-yourself" health texts and educational programs, the development of health care technologies particularly suitable to home use has facilitated self-care. The blood pressure cuff is now available as a home health aid, as is a pregnancy testing kit. Technology required for hemophiliac and renal disease care are similarly within the range of both the competence and economic resources of laypersons for home use. Redesign of traditional professional technology for lay use can be expected to continue. Indeed the home as a physical plant itself may be modified to accommodate lay health activities. All of this suggests that lay health care has grown beyond the earlier stage of "home remedies."

The de facto revision of medicine's social charter which is occurring through the growth of self-care and mutual aid groups has not been paralleled by a change in the legislation embodied in the medical practice acts. Although it appears that self-care users have not been prosecuted under the acts, unauthorized practice suits have been brought against women's health groups and in many states the language of the medical practice acts is on its face broad enough to encompass self-care. However, there are constitutional as well as social and economic reasons for allowing self-care and mutual aid groups to perform health care services. In order to determine how the acts should be interpreted (or even amended) to reflect these concerns, it is necessary to examine the goals and the coverage of the medical practice acts.

Scope of the laws

The authority to enact laws governing the practice of medicine belongs to the states, rather than the federal government. According to a 1910 Supreme Court case, *Watson v. Maryland,* the states have the power to regulate trades and businesses essential to public health "unless such regulations are so unreasonable and extravagant as to interfere with property and personal rights of citizens, unnecessarily and arbitrarily." An earlier Supreme Court case, *Dent v. West Virginia* explained the justification for the medical practice acts.

Everyone may have occasion to consult [a physician], but comparatively few can judge the qualifications of learning and skill which he possesses. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualification.

Although the medical practice acts of each of the 50 states and the District of Columbia differ slightly, they appear to have as their main
goal the protection of the public from unqualified practitioners who make their living by diagnosing or treating people. A 1973 Texas case stated that prohibitions against unauthorized practice of medicine were enacted throughout the nation to “protect the populace from the early medical quacks and charlatans.” The court noted that such statutes were adopted “in the wake of a stream of public abuse at the hands of the entrepreneur medicine man purveying his snake oil elixir.”

In order to assure that health care consumers have accurate information on which to base their choice of a provider, the medical practice acts regulate the interaction between the practitioner and the public in general. Thirty-six states prohibit unlicensed practitioners from holding themselves out to the public as ready to engage in the practice of medicine and surgery. Moreover, the medical practice acts attempt to prohibit unlicensed practitioners from misleading the public into thinking they are licensed. Thirty-four states prohibit the use of the title “Doctor” by laypeople, and 18 states prohibit laypeople from opening an office for the practice of medicine. Some states further protect the public by imposing high penalties for fraud in obtaining a license.

One would think that the definition of the practice of medicine would be limited to providing services for a person in an abnormal condition, such as someone suffering from an ailment or injury. But, a practitioner can be someone who provides services for another’s condition, abnormality, complaint, pain, ailment, disease, injury, deformity, or defect. This means that licensed professionals have a monopoly on the care not only of abnormalities but also of “conditions” (such as pregnancy) in 19 states. The Wisconsin act goes even further by making it a crime for laypeople “to examine the fact, condition or cause of human health or disease, or to treat, operate, prescribe or advise for the same, by any means or instrumentality.” (Emphasis added.) Minnesota’s definition of the healing acts includes “examining into the fact, condition, or cause of human health or disease” for any fee, gift, compensation, or reward. Since this is broad enough to cover all public health activities in the state, the Minnesota legislature had to declare that various scientific, sanitary, or teaching personnel whose duties are entirely of a public health or educational character should not be considered to be practicing medicine.

The far-reaching nature of the medical practice acts is indicated by the fact that 25 states have passed special legislation to exempt medical students so that they will not be charged with the crime of unauthorized practice of medicine. At least nine states have a similar exemption for masseuses. Spiritual health care is within the province of laypeople due to a general religious exemption in 35 states and a specific Christian Scientist exception in 13 states. Thirty-five medical practice acts give laypeople the right to practice medicine in an emergency, although 14 of these acts specifically limit this exception to situations where no compensation is expected or received.

Self-care and the advice and assistance given by mutual aid groups is given some sanction by at least one act: Missouri exempts laypeople

*International Digest of Health Legislation, 1981, 32 (1)*
who render "isolated or occasional gratuitous service to and treatment of the afflicted." Connecticut and Louisiana have built-in self-care exceptions since their definitions of the practice of medicine include only acts done to human beings other than oneself. A more common exception which covers many self-care situations is "the domestic administration of family remedies." The application of this exception resulted in the acquittal of the Los Angeles feminist who treated a woman's vaginal infection with yogurt. Variations on this exception occur in 28 jurisdictions, although two limit it to gratuitous administrations, four limit it to cases of emergency and three limit it to administrations to family members. Even without such limitations, the domestic administration of home remedies exception may not be a panacea for users of self-care. Although it would clearly cover the use of such things as yogurt treatment, cough syrup, or chicken soup, its application to skills of the sort taught in a Sehnert Activated Patient course or a Yale self-care class has not yet been determined. A Kansas court defined the domestic remedy as one which is commonly kept by non-professionals in their homes, has an effect that is a matter of common knowledge, and requires no specific training for administration. Under such a definition, even insulin treatment for a diabetic might not qualify as an exempted domestic remedy since its effect is not commonly known to people who are not diabetics and it requires at least some training for administration.

Despite the broad sweep of the statutes, courts have given some indication that the acts should not be applied to the use of self-care. Although it appears that the issue has not been faced squarely by the courts, some have commented in dicta about the absurdity of regulating intra-family health care or friendly services. In a 1924 case, the constitutionality of the West Virginia Medical Practice Act was challenged on the grounds that it could be read to prohibit a mother from administering the simplest home remedy. The court held that the hypothetical situation was not prohibited since the statute should receive a reasonable interpretation.

An early case held that the Alabama statute regarding the unauthorized practice of medicine does not prohibit "merely casual or friendly services." More recently, the California Supreme Court held that the state legislature, which passed the religious, emergency, and domestic administration of home remedy exemption, intended that the prohibitions of the act apply only to persons actually purporting to practice the healing arts. It stated that:

Informal recommendation among friends as to the efficacy of nonprescription vitamin compounds or ocean cruises seems akin to sharing a "family remedy", as does the presence during childbirth of a husband, friend or relative who merely offers verbal reassurance, soothing massage, or assistance in breathing exercises.

In a 1960 New York case dealing with a chiropractor's "prescription" of vitamins to an individual, the court noted a specific exception
for an individual using self-care, however its decision may create some problems for self-care courses or mutual aid groups. The court stated:

While there is no law prohibiting anyone from administering medicine for and to himself, the law does prohibit another, who is not qualified or licensed to do so, from prescribing such medication to someone else.\(^{47}\)

This decision may have the effect of making it difficult for people to pass on their self-care ideas to other interested individuals.

The distribution of information about self-care even by licensed individuals may be hindered by certain provisions of the medical practice acts. In Connecticut, people face a maximum $500 fine and year in jail if they "give or attempt to give training in any branch of the healing arts or any subdivision thereof, or aid or participate in the same, without first having received permission to do so from the general assembly."\(^{48}\) Moreover, 38 states provide that a physician's license can be revoked if he or she aids or abets an unlicensed person in practicing medicine.\(^{49}\) Since the parameters of illegal practice are not clearly defined, a physician might decide not to pass on self-care information to patients or teach a class in self-care for fear of losing the license to practice.

**Professionals vs. self-care**

The organized transmissions of health care information through do-it-yourself health texts or health education programs might present a likely target for action under the medical practice acts because they present a greater economic threat to organized medicine than do the actions of a single individual using self-care techniques. The medical practice acts give extensive power to doctors and medical groups who may view self-care as an economic threat.

In Florida, each licensed physician is seen as a guardian of the public interest who has the power to bring suit to stop what appears to be the unauthorized practice of medicine.\(^{50}\) In most states, the medical board has the power to bring a suit for an injunction to stop the health care activities of unlicensed persons. The Texas Medical Practice Act additionally gives the Texas board the power to issue subpoenas and to hold hearings which need not even meet court standards regarding the rules of evidence or procedure.\(^{51}\)

The propriety of giving physicians investigative and enforcement powers under the unauthorized practice of medicine statutes is questionable since organized medical groups have used their control over entry into the field to maintain fees at an artificially high level.\(^{52}\) Moreover, in states like Ohio\(^{53}\) and Tennessee,\(^{54}\) where the board receives half the fines collected as penalties in unauthorized practice suits, there is further economic incentive for it to crack down on lay practitioners.

If physicians do react to the economic threat of organized self-care programs by initiating suits against the unauthorized practice of  

*International Digest of Health Legislation*, 1981, 32 (1)
SELF-CARE AND THE LAW

medicine, the self-care instructors and self-care users will have a number of defenses. Self-care instructors could argue that teaching is not within the act at all because there is nothing resembling a doctor-patient relationship since conducting classes does not involve solving a particular individual's health problems.

In Hurley v. People,55 a layperson conducted a school for healing, offering a 72-hour course primarily dealing with posture. Although the trial court found him guilty of the unauthorized practice of medicine and chiropractic, the Colorado Supreme Court reversed this decision. They held that a Colorado citizen has a constitutional right to teach any branch of learning that is not inherently injurious or harmful to the public health, safety, or morals and to charge for his or her services. He or she also has the right to do anything necessary for the explanation of the principles involved, including demonstrations, "provided that same is not done with the purpose, intention or expectation of relieving the person who is then being demonstrated upon from any pain, suffering, injury or disease."56

Both self-care instructors and self-care users could argue that even if their actions appear to be within the general scope of the act, there are statutory or constitutional reasons to exempt them. If the domestic administration of family remedies exception is available, the proponents of self-care could argue that their actions fall within the exception. They could argue that the statute is unconstitutionally vague57 as not providing adequate notice to citizens regarding what constitutes a violation of the statute, or is unconstitutionally overbroad58 as prohibiting actions which should clearly be legal. They also could claim that the fundamental constitutional rights of liberty,59 free speech,60 freedom of association,61 and privacy cover their actions.

Thus far, courts have repeatedly dismissed challenges to the medical practice acts based on the general claims of vagueness and overbreadth.63 Chances of success will be greater if the statutes are challenged as violating fundamental rights. The state, then, would have to show a "compelling" state interest in order to justify the regulation64 and the state would have to convince the court that potential harm to the individual outweighs the value of the fundamental right asserted. The controversy will become an empirical battle with the state trying to show the dangers in lay practice and the proponents of self-care bringing in evidence of its safety, the beneficial effect on the patient of participation in health care decision-making, and the comparative harm of professional care.

Holding such battles on a case-by-case basis would be costly to the self-care movement in time and money by forcing a new adjudication each time a different medical skill is passed on to laypeople. Moreover, individual self-care users or self-care instructors might be afraid to challenge the medical practice acts because of the severe penalties for practice without a license or for aiding and abetting such practice.65 The punishment for unauthorized practice in Kansas is a mere $50-$200, fine,66 but most other states authorize a combination of fine

International Digest of Health Legislation, 1981, 32 (1)
and imprisonment, with Indiana imposing the strictest penalty, a $1,000 to $5,000 fine or two to ten years imprisonment or both. Missouri provides that the treatment of each patient constitutes a separate offense and Alaska, Arkansas, Colorado, Hawaii, Montana, Oklahoma, Texas and Virginia provide that each day of practice is a separate offense. Both the per patient and per day provisions could weigh heavily on on-going mutual aid groups or self-care education classes and raise the penalties substantially.

Because of the difficulties of a case-by-case clarification of the medical practice acts, a legislative amendment seems advisable. Just as the medical practice acts have been changed in recent years to accommodate new professionals such as physicians’ assistants and mobile intensive care paramedics, the acts can be modified in recognition of the growing trend for the consumer also to be the provider. Two concerns must be kept in mind in drafting such an amendment: the first is the state's interest in protecting the public as a whole from harmful health care practices and the second is the individual’s right to choose treatment. The latter concern is the result of the legal trend toward self-determination in health care which has developed since the initial passage of the medical practice acts. It was expressed by Cardozo in a 1914 New York case: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.” And it is most recently invigorated by the recent constitutional decisions giving individuals access to medical technologies such as contraceptives and abortion, but also by cases which give patients the right to refuse treatment. In a 1962 New York case, the court concluded that it is the individual who is the subject of a medical decision who has the final say and that this must necessarily be so in a system of government which gives the greatest possible protection to the individual in furtherance of his own desires.

The high regard for patient decision-making is also demonstrated by what was termed in a 1957 California case as the informed consent doctrine. This doctrine holds practitioners liable for not informing patients about the risks and alternatives of a proposed treatment. A revised medical practice act would maintain the current provisions for dealing with the interaction between the practitioner and the public. It would prohibit unlicensed people from representing themselves as a practitioner of the healing arts, from opening an office for such a practice and from using a title such as “Doctor” which represents them to be licensed even though they are not. These provisions prevent harm to the public which results when individuals mislead the public into thinking they have an ability they do not have. Society’s increasing recognition of the value of self-determinism in health care, however, suggests a need for a modification of the provisions governing the interaction between the practitioner and the health care consumer. This need also is suggested by the alternative means of protection which have developed since the passage of the original
medical practice acts. In the case of potentially dangerous drugs, the FDA already limits the power to prescribe to licensed physicians. And in allowing sale of other drugs over-the-counter, the FDA has conceded that the value of giving lay people access to the treatment outweighs its potential harm. In the case of treatment other than with medicine, compensation for any harm that occurs as a result of lay practice is available under the traditional tort doctrines such as negligence and, presumably, under an extension of the informed consent doctrine to lay practitioners.

Although an extensive reevaluation of the acts would be required to reflect modern health care needs, a revision can be drafted which would fulfill the immediate goal of clarifying the status of self-care and embracing constitutional guarantees. This amendment would limit the application of the acts to those who provide services for pay. This revision assumes that a health care provider is more apt to act in the patient’s best interest when it does not conflict with the provider’s potential economic interest. Moreover, it reflects the practical consideration that a person who receives health care service from a family member or a member of a mutual aid group is already aware of the level of skill of the provider. It seems most unlikely that one spouse would be able to trick the other into believing the falsehood that he or she was a physician.

Revising the medical practice acts to apply only to those who claim expertise in the healing arts (by holding themselves out to the public at large as engaged in the healing arts, opening an office for that purpose, using a misleading title, or charging for their services) overcomes the constitutional deficiencies in the current statutes. As the California Supreme Court stated in a 1977 case, 76

The state, while subject to constitutional prohibitions against any limitation on the advice given among friends, clearly has a strong and demonstrable interest in protecting its citizens from persons who claim some expertise in the healing arts, but whose qualifications have not been established by the receipt of an appropriate certificate.

Another suggested modernization of the medical practice acts would be the requirement of lay representation on the state medical boards. This is already being done in South Dakota 77 and West Virginia. 78 The Maryland Act contains the further provision that “The Board, before promulgating regulations, shall invite and consider proposals from individuals or health groups which would be affected.” 79 By requiring lay representation on the board and by assuring the board’s consideration of the needs of groups other than licensed physicians, the medical practice acts could be made more sensitive to the interconnection between provider and consumer.

The extent of the popularization of health and medical care is yet to be fully documented. Nevertheless, there is evidence that changing disease patterns, developing health care technologies, and patient education programs have encouraged people to take much of primary health
care competently into their own hands. A close look at the state medical practice acts reveals that their broad language could conceivably encompass people who use medical skills on themselves and their families. Courts appear to recognize, however, that the prohibitions against practicing without a license should not be applied to the users of self-care. Revision of the medical practice acts to limit their application to practitioners who provide services for a fee is nonetheless advisable. In addition to being consistent with the original goals of the acts to regulate those who practice as a profession, such a revision will avoid unnecessary litigation and encourage the use of health care resources on a self-service basis.

Notes


14 Interview with Marilyn Skerbeck, Los Angeles Feminist Women’s Health Center, March 10, 1978.

22 Levin, op. cit.


The numerous legal citations which support the ideas in this article, though numbered as footnotes in the text, have been omitted. They are available from: Lowell S. Levin, Dept. of Epidemiology and Public Health, Yale University School of Medicine, New Haven, CT 06510.

International Digest of Health Legislation, 1981, 32 (1)
Denmark

Contribution by Johannes Nehm

Any discussion of the influence of legislation in Denmark on the practice of self-care must largely be based on the traditionally liberal Danish attitude towards the individual’s right to decide what happens to his own body. The most convincing example of this attitude is the fact that attempted suicide — the extreme form of self-care — is not a crime under the Criminal Code. This liberal attitude has influenced both the legislator and the interpretation of the legislation. It is thus taken for granted that the prohibition on injections by unlicensed persons does not prevent such persons from treating themselves, their spouses, or their children for diabetes by means of insulin injections. In certain very rare cases (see below) treatment by a physician is compulsory, but as a rule there is no restriction on the domestic administration of “family remedies”.

The legislation governing medical practice in the widest sense is extensive, ranging from the Law on measures to control communicable diseases to the Law on social assistance.

Categories of licensed personnel

The following categories of health personnel are subject by law to licensing (in all cases the professional qualification is protected, and in a number of cases the exercise of the activity itself):

<table>
<thead>
<tr>
<th>Profession</th>
<th>Protection of qualification</th>
<th>Protection of activity</th>
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<tbody>
<tr>
<td>Physician</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dentist</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical dental technician</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Nurse</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Midwife</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Chiropodist</td>
<td>Yes</td>
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The Law on the practice of medicine lays down general principles governing medical practice under the following eight Chapters: the right to practise medicine; special provisions on the right to prescribe dependence-producing substances; duties of the physician; medical practice in relation to public authorities; payment for medical care; supervision and liability; and unqualified practice.
The range of restrictions

The provisions of the above-mentioned Law concerning unqualified practice are of interest with regard to those aspects of self-care that go beyond self-treatment. In principle, unqualified practice is not prohibited in Denmark, and a wide range of treatments are therefore carried out with or without payment. However, unlicensed persons may not:

1. design themselves as physicians or in any other manner that is likely to suggest that they are licensed as physicians; the penalty is a fine (Section 23 of the Law);
2. treat sick persons if they expose such persons' health to demonstrable danger; the penalty is a fine or imprisonment (Section 24);
3. treat persons for venereal diseases in the communicable stage, or any other infectious diseases; the penalty is up to 12 months' imprisonment (subsection 1 of Section 25) (the fact that the lay healer was unable to recognize the nature of the disease is not a mitigating circumstance);
4. administer general or local anaesthesia, render obstetric assistance, administer prescription medicaments, or apply X-ray or radium treatment or therapy involving electric apparatus whose use is subject to licensing, in the absence of medical or other legally approved qualifications to do so; the penalty is up to 12 months' imprisonment (subsection 2 of Section 25 of the Law) (under a verdict issued by the Supreme Court of Justice, acupuncture is included in this prohibition);
5. treat sick persons if the healer is not a citizen of Denmark or of another EEC Member State and has not been resident in Denmark for 10 years, unless authorized to do so by the Minister of the Interior, or if treatment is carried out on an itinerant basis; the penalty is a fine or up to three months' imprisonment (subsection 1 of Section 26); and
6. inform the general public or strangers, by means of advertisements (other than details of address), signboards, or leaflets, or in any other way, that they engage in the treatment of patients; the penalty is a fine (subsection 2 of Section 26).

The above-mentioned six points cover the full range of prohibited acts of self-care. However, it is permitted to teach others self-care in this or any other field provided that injury does not result. Very few cases are ever brought before the courts, even though the amount of popular literature and lectures on self-treatment, self-diagnosis, and health promotion has considerably increased in Denmark since the mid-1970s.

Sections 23-27 of the Law are rarely invoked by the National Board of Health or the courts. Over the last 10-15 years, the prevailing offences that have come to trial are cases of unlawful designation as a physician, unlawful advertising as a healer, treatment resulting in injury,

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\[\text{International Digest of Health Legislation, 1981, 32 (1)}\]
treatment that has prevented patients from consulting a physician, and acupuncture. The procedure is usually that the National Board of Health receives a complaint, investigates the matter either through the local medical officer of health, the police, or both, and finally applies for prosecution. The result is usually a fine or, in cases of serious injury, imprisonment.

**Compulsory medical care**

Medical care is compulsory only in a very few cases, the chief of which are as follows:

1. A person who has reason to believe that he is suffering from a venereal disease must consult a physician for diagnosis and treatment;
2. The county epidemic commission may order persons suffering from diseases that constitute a public health hazard to be placed in isolation and if necessary hospitalized;
3. The closest relatives of a person presumed to be mentally ill must call in a physician. If, upon examining the person, the physician considers it necessary for the person to be admitted to a mental hospital (either because the person is dangerous to himself or others or because his chances of recovery would otherwise be substantially reduced), the relatives must arrange for such admission, if necessary with the aid of the police; and
4. All children of school age must be attended by the school health service, including four or five checkups by a physician.

**Health insurance**

Denmark has a legally based system of sickness and maternity benefits, which are mainly available to persons earning an income. Most of these and other welfare and medical benefits (disability pensions, prostheses, physiotherapy, domiciliary nursing, etc.) are provided through the public health service.

**Conclusion**

In addition to the above, it may be stated that since the beginning of the 1970s there has been increasing interest in and support for self-care and the related concepts of health education and health promotion. Examples of this include local initiatives to provide health promotion courses, etc. that are open to the general public, and health education increasingly forms a part of the basic and further training of all categories of health personnel. At the central administrative level, a major step was taken by the Minister of the Interior in setting up a committee whose 1977 report on priorities in the health services included a recommendation that an intersectoral Prevention Council be established. The Council was eventually established in 1979, and one of its
first tasks has been to set up a working party to collect information on new trends in health education and advise the Council on possible initiatives in the area of prevention.

In addition, one county council has set up a committee on health education, the Ministry of Education organizes courses and conferences on the subject, and health problems are repeatedly discussed on television. Thus, there is now a firm realization that the individual’s sense of responsibility for the health of his own mind and body is essential to the health of the general population.

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**England and Wales**

*Contribution by John D. Williamson*

British law is intended to maintain stable balance between the liberty of the individual and his duty to society. Traditionally, legislators have followed the dictates of J. S. Mill in holding that:

The only purpose for which power can rightly be exercised over a member of a civilised society is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant.

The European argument that it is useful to define deviance because this gives a sense of unity to those people who define themselves as “not deviant” has been largely rejected on the grounds that any minority could then be deemed deviant if the majority so wished.

Conflict between these two opposing views has only achieved importance in the United Kingdom during the past 20 years, during which legislation has been proposed against smoking, drinking, and driving while under the influence of alcohol or without wearing seat belts. Jurists are divided on these issues between libertarians and moralists but, since the essential debate is largely unresolved, the precedent of personal liberty must for the time being remain pre-eminent.

United Kingdom law is not so much a system of rules as rules based on a system of principles, and it is the interpretation of these principles that is at the heart of the legal process. Law is made in three ways. Firstly, law is made by act of Parliament (statute). Secondly, the right to legislate may be delegated by Parliament to some other body or person, although it remains strictly monitored by Parliament. Thirdly, there is case law which consists of decisions by judges (judicial precedent). No single one of these is absolute. All statute and delegated legislation is based on some principle or other and, even where such law does not require interpretation by the courts, the question of whether the principle at stake is applicable to the particular situation needs to be

*International Digest of Health Legislation, 1981, 32 (1)*
carefully considered. In case law, not everything that is said is binding; only that which constitutes the grounds for the decision (ratio decidendi) is to be followed, and the remaining statements (obiter dicta), which are not strictly the basis of the decision reached, can be ignored in subsequent cases. However, since the relation between the two is nowhere defined, it is frequently difficult to ascertain the relevance of a given ruling to a new case, and in any event higher courts are not bound by decisions of lower courts.

One final complication is that the United Kingdom is subdivided for legal purposes into: (a) England and Wales; (b) Scotland; and (c) Northern Ireland. Only England and Wales are automatically subject to the same provisions unless specifically stated otherwise. Scotland and Northern Ireland each have their own legal procedures, often involving markedly different interpretations of transgressions and defences. For simplicity’s sake, therefore, only the law pertaining to England and Wales will be considered below.

Medical protectionism

The 1858 Medical Act established the pattern of State regulation of medicine which still applies. It set up a body, later to be known as the General Medical Council, with powers to supervise the training of physicians, to maintain a medical register and an official pharmacopoeia, and to administer a disciplinary code which made it possible to strike off the register any physician convicted of a criminal offence or proved guilty of “infamous conduct in a professional respect”. The Act does not prohibit the unqualified practice of medicine (except with regard to venereal diseases or childbirth), provided that the healer does not represent himself to be a registered medical practitioner:

Any person who wilfully and falsely pretends to be or takes or uses the name of Physician, Doctor of Medicine, Surgeon, General Practitioner or Apothecary, or any name, title, or description implying that he is registered or that he is recognised by law as entitled to one of the above descriptions is liable....

It is thus quite acceptable for a person to practise osteopathy provided he calls himself an osteopath and not an osteopathic surgeon or a manipulative surgeon.

In short, the purpose of the Medical Act was to allow the public to easily identify a genuinely registered physician. Although protection of the profession was an important factor, it was the protection of the public that lay behind the drafting of the original Act and its subsequent amendments.

The sharing of medical knowledge and skills with the layman is no longer frowned upon. This was positively endorsed by the Royal Commission on Medical Education:

[The] typical patient of the future — who will be better educated and better informed about health dangers — can be expected to take more responsibility for the

*International Digest of Health Legislation, 1981, 32 (1)*
management of trivial and self-limiting complaints, provided he is given the necessary encouragement and guidance by the medical profession.6

And here we come to the crux of the matter. The medical profession in the United Kingdom is either directly employed by or contracted to the National Health Service, which offers comprehensive medical care to everyone, free of charge at the time of use. Remuneration is not dependent on the amount of work undertaken but on the scope of the responsibilities for which the practitioner has contracted. There is therefore no economic incentive to discourage self-care. Furthermore, there is no particular problem associated with promoting self-care in a given community. Of course, as is the case with many other health policies, not all physicians approve of self-care, but there is no legal provision that prevents the patients of one physician from attending self-care classes or activities organized by another. Since physicians are not in economic competition with one another, there is not even a professional problem. Perhaps this point is best summarized in a letter sent to me by the Legal Department of the British Medical Association on the matter of admitting other physicians' patients to self-help groups run by myself:

If you were to have in the group other doctors' patients, it might be courteous for you to let them know that they were attending your group, although I imagine they would be only too pleased that you are helping their patients.7

Clearly the nature of the National Health Service is an important factor in the development of self-care.

One difficult problem for physicians who are interested in self-care is the question of referral to unregistered practitioners. This could be seen as an example of "infamous conduct in a professional respect", resulting in being struck off the Medical Register, even though the criteria for being struck off have never been adequately defined. A recent statement by the General Medical Council holds that "a doctor who improperly delegates to an unregistered person duties or functions regarding the knowledge and skill of a medical practitioner"8 is guilty of infamous conduct, although what this means in precise terms is not clear. Nevertheless, on the basis of the statement by the Royal Commission referred to earlier, it is obvious that the Council's objection is to other kinds of professional healers rather than to persons practising self-care.

Lay practitioners of self-care

Lay persons are relatively free to practise self-care as they think fit, the only constraint being that they must be prevented from doing inadvertent damage to themselves. Two issues deserve special mention here: the preference for remedies that are not medically prescribed, and "self-neglect".

Remedies may be self-prescribed or prescribed by another person

International Digest of Health Legislation, 1981, 32 (1)
whether or not they are registered under the Medicines Act. The only legislative provisions of relevance here are those concerning the sale and supply of "medicinal products" i.e. substances whose primary use is in medical treatment of one kind or another. The legislation provides the statutory control over the advertising and sale of a wide range of products (other than instruments, apparatus, or appliances) and in so doing helps to establish a defined range of treatment suitable for self-medication or medication by a non-registered practitioner. The scope of the statute is wide, encompassing the treatment and prevention of disease, diagnosis, or "interfering with the normal operation of the physiological function". Only compounds which are particularly dangerous on account of toxicity or habituation are denied to lay practitioners other than under a prescription made out by a registered physician.

Self-neglect is something which society tends to condemn. However, the law holds that the individual has the right to neglect himself provided that he does not cause danger to others and is capable of thinking for himself. There are, however, a number of specific provisions to the contrary. The Public Health Act of 1936 gives authority for the compulsory detention in hospital of any person suffering from a specified communicable disease so as to prevent its spread. The National Assistance Act of 1948 gives the Department of Social Services authority to apply for a court order for the statutory detention of a person "suffering from grave chronic disease, or being aged, infirm, or physically incapacitated, [who] is living in insanitary conditions, and is unable to devote to himself and is not receiving from other person proper care and attention". A later amendment sped up this procedure so that such a patient could be detained for up to three weeks under a magistrate's order, but in practice very few such orders have ever been issued.

The major mechanism of detention for perceived neglect is the Mental Health Act 1959. Under Section 29, a relative or social worker may, subject to certification by at least one physician, apply for the detention for up to 72 hours of any person suspected to be suffering from a mental disorder (which does not need to be specified). Further certification can subsequently be obtained under other Sections of the Act, but these are subject to far more safeguards than the emergency admission procedure. Under Section 135, a magistrate can authorize entry to premises where it is suspected that a mentally disordered person is being held and ill-treated or is "unable to care for himself and is alone". Under such circumstances entry must be made by the police, the certifying physician, and a social worker in concert. The most controversial Section of this Act, and one that is vigorously opposed by the National Council of Civil Liberties and the National Association for Mental Health, is Section 136, whereby a police constable can compulsorily detain any person found in a public place and suspected of suffering from a mental disorder. It is in fact likely that this Section will be repealed in the near future.
The above provisions cover the entire scope of legal State interference in the state of health of an adult. However, in the case of children, there is an additional factor: the Children and Young Persons Act of 1933 originally prescribed that if a child was neglected he should be taken into care by the authorities. Subsequent amendments have increased the responsibility of parents in this matter until today a child can be taken into care if he is subjected to behaviour "likely to cause him unnecessary suffering or seriously affect his health or proper development" or if "these... are likely to happen because they occurred to another member of the same household". Clearly, in such instances, the rights of the child are not subordinated to those of the parent.

Negligence

Perhaps the only other important tangential consideration regarding self-care is the question of liability. There is, of course, no liability for self-inflicted damage, but there is a legal duty to protect others for whose care responsibility has been assumed. Under British law, the legal duty of the layman is assessed in terms of what "the average man on a Clapham omnibus" might reasonably be expected to do in similar circumstances. There can be no action for damages against such a reasonably acting lay person unless he has assumed a duty to exercise diligence. Such a duty is deemed to have been assumed whenever a person purports to be able to undertake a specific task and, under British law, undertaking to carry out the task is equivalent to claiming to the patient that it can be done adequately. If a person without medical knowledge decides to treat a patient rather than call in medical assistance and death results, that person will be guilty of manslaughter.

The position regarding physicians is slightly different. Negligence is measured in terms of the "degree of care as a normally skillful member of the profession may reasonably be expected to exercise in the actual circumstances of the case in question". Should harm befall a patient when the doctor acts in accordance with this standard, then the verdict would be misadventure and a suit for damages would fail. However, if the standard of care were judged to have fallen below the accepted standard, then the physician would be guilty of negligence and could be sued for damages. If it were shown that the physician deliberately offered substandard care while knowing the probable outcome of his actions, he would be guilty of criminal negligence. Should death occur in either case, the physician would be guilty of manslaughter. However, the physician's responsibility does not end there; he has vicarious liability for the actions of any other person he allows to treat his patient. It may be assumed that this would raise problems for self-care programmes involving unlicensed healers, but this is not necessarily the case. Liability only arises if the physician aids and abets negligent action, in other words if he "knows of the essential matters which constitute the offence". It is very rare for physicians to be so closely involved with other healers; all that medical personnel
would normally do is to "counsel or procure" healing by non-registered healers, and it has been ruled that this is not the same as "aiding and abetting". 17

Finally, what of the role of families? What is quite obvious from earlier comments is the legal duty of parents to care for their children. Under the Children and Young Persons Act 1933, a parent who fails to call in a physician to attend a sick child is guilty of neglect although, if the child recovers, this is not held to be an offence. However, if the child dies, then the negligent parents are guilty of manslaughter provided it can be shown that they had intended death. 18 Similar duty extends to spouses; if the sick person dies without the benefit of medical attention, then the surviving spouse will be guilty of manslaughter if it is shown that he or she could foresee the outcome of the neglect. 19 Thus, while civil damages are not likely to be sought in a family situation, it is assumed that there is a "responsibility for the medical care of another" and the test of legal duty is the foreseeability of damage rather than its cause. The degree of kinship to the person to whom the duty is owed is irrelevant in British law. 20

Self-care and the law

Since self-care is not specifically mentioned or described in British legislation, it may be assumed that its practice is not illegal. There are, in fact, few constraints on practitioners of self-care, and the few that do exist and that have been outlined in this brief review are general in tone, obvious in intent, and clearly irrelevant to the majority of types of self-treatment. It is thus unlikely that there will need to be a major revision of British law in order to encourage the further development of self-care.

Acknowledgments

I would like to thank Mr J. Danaher, Department of Legal Studies at Leeds Polytechnic, for his help and advice. I would also like to thank the Legal Department of the British Medical Association for their views.

References

7. Personal communication dated 4 July 1980 from the Legal Department of the British Medical Association.
Federal Republic of Germany

Contribution by Christian von Ferber

Self-treatment and self-care are legally restricted on the one hand by provisions for the protection of the professional interests of the medical and non-medical health professions and on the other hand by penal law.

Legislation governing the health professions is intended to protect the activities of physicians and other health professionals against competition from persons practising healing on a commercial or professional basis although not licensed to practise any of the health professions. By definition, therefore, self-treatment cannot infringe the professional rights of the health professions. Care dispensed to others, however, is a different matter.

Provided that the care dispensed to others remains outside the bounds of commercial or similarly remunerative exchange or only occasionally involves remuneration, the health professions have no defensible interest in restricting such self-care. Domestic care of sick members of one’s family, and mutual assistance among relatives, neighbours, friends, and colleagues — within one’s so-called “social circle” — can be carried on without hindrance from the ostensibly conflicting professional interests of the health professions. However, conflicts may still arise as a result of two current developments.

In the field of preventive health care, a large number of lay activities have developed over the past decade: self-care groups, establishments such as health centres that are sponsored by health in-

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*a* Prepared in collaboration with Mr Heinrich Jocks.

*International Digest of Health Legislation, 1981, 32 (1)*
insurance funds, and commercial associations such as "Weight Watchers". From the point of view of health policy, such types of organization have a definite place in promoting a healthy lifestyle. However, a conflict of interests with the practice of medicine would arise should health counselling be introduced as a "reimbursable service" (in other words, a standard service under the terms of health insurance legislation); an agreement along these lines between the Kassenärztliche Vereinigung Nordrhein (an association of physicians under contract to health insurance funds) and a number of health insurance funds is currently being discussed. The health centres sponsored by health insurance funds, as well as commercial organizations, would then have to bring their activities into line with the health counselling provided by physicians. In other words, an extension of the activities of physicians into the field of prevention is likely to lead to a conflict of interests with lay practitioners who are already active in this area. However, at the moment it is still doubtful whether physicians are specifically competent in matters of health counselling. Surely what is involved here is not merely the determination of states of risk in what might be termed "pre-patients" but also, and more particularly, counselling on matters of daily living which may give rise to health hazards.

At the same time it may be foreseen that, if the idea of self-care should spread further, types of organization will arise that will eventually take on remunerated curative duties and thus encroach upon the central sphere of activity of physicians. Such types of organization may develop on an ideological basis with a view to providing alternative forms of medical care, or may arise on practical grounds in order to make up for shortcomings in the existing system of care. Examples of this are various types of care dispensed to drug-dependent persons, and gynaecological self-care by women, as well as associations for the improvement of psychosocial and psychiatric care. Some of these cases involve marginal areas of medical care in which interaction with other professions (social workers, psychologists, etc.) becomes essential or in which the duties of physicians are quite simply delegated to other professions. In other cases, however, what is involved is the recapturing of medical activities which previously had to be abandoned owing to a shortage of physicians (for instance in the field of psychiatric care). The anticipated increase in the number of physicians in the 1980s and 1990s could upset the hitherto existing state of peaceful coexistence.

To sum up, it will be seen that self-treatment and self-care can be carried on freely for the reason that competition with health professions whose interests are protected by law only arises in the case of commercial organizations which, by definition, have nothing to do with self-treatment and self-care. In the future, conflicts of interest between the health professions and self-care are conceivable because both are in the process of expanding and are tending to overlap with one another. The number of physicians will double by the year 2000. Self-care has

*International Digest of Health Legislation, 1981, 32 (1)*
already become very firmly established in the various unoccupied nooks and crannies of the medical care system. The self-care movement is gaining in self-awareness and is already seen by many sectors of the population as an alternative to medical care.

Another legal restriction on self-treatment and self-care is penal law. The latter is intended both to protect physical and mental integrity and to reinforce certain moral ideas. Self-treatment is subject to legal penalties only if another person is involved (self-mutilation or suicide assisted by another person). Self-care, in other words the treatment of others by means of non-commercial exchange in the form of a non-profit-making association, etc., is liable to legal penalties if physical injury or immorality is involved.

Under the legal system of the Federal Republic of Germany, self-treatment and self-care are seen as valid forms of individual autonomy and social self-organization, and as such are legally protected.

The legal limits of self-treatment and self-care are reached in situations where other legally protected entities (the practice of recognized professions, physical integrity, and morality) are infringed. These legally protected entities enjoy legal protection in a manner that is expressly defined (see the Industrial Code, the Federal Rules concerning physicians, the Lay Healers Law, and the Penal Code).

A conflict between individual autonomy and the right to self-organization on the one hand and the right to practise recognized professions, the right to physical integrity, and the right to the recognition of a certain view of morality on the other hand is therefore likely to result in a legal conflict only in certain very limited circumstances. The legislator and the courts have therefore intervened only where essential interests are violated.

Netherlands

Contribution by

Marja van Doorn-de Leeuw
and Josette Hessing-Wagner

1. Introduction

Although this article does examine whether Dutch law impedes the practice of self-care as understood by Andrews and Levin, our emphasis will be on what is a typical problem of the Dutch welfare state, viz. the growing dependence of individuals upon benefits provided through a complicated system of detailed legislation. After a short description of professional and non-professional health care in the Netherlands (Sec-

International Digest of Health Legislation, 1981, 32 (1)
tion 2), we will show that in practice Dutch health legislation is not a direct obstacle to the practice of self-care (Section 3). If, however, the system of benefits provided in a welfare state is seen as leading to decreasing self-reliance among people, the health legislation of such a state is in fact an indirect obstacle to self-care.

2. Health care in the Netherlands

2.1 Professional care

The professional health care sector in the Netherlands can be divided into intramural (institutional) and extramural health care. Intramural health care is provided through hospitals, mental institutions, and nursing homes, while extramural health care covers the care provided by general practitioners and dentists, extramural midwifery, extramural and outpatient treatment for external ailments, domiciliary care, and ambulatory mental health care. Ambulatory mental health care is provided through a number of specialized services, such as social psychiatric services, child guidance clinics, multidisciplinary psychotherapy institutes, psychiatric services for youth, centres for alcoholics and drug-dependent persons, social educational services (ambulatory care for the mentally handicapped), and socio-psychological geriatric services.

The general practitioner is the principal point of entry into the health care system. He can refer the patient to other health services at either the primary health care level or a higher level such as specialist care or intramural care. Most general practitioners work independently; in recent years, however, cooperative ventures (group practices and community health centres) have grown in number. Specialists and other health care personnel usually work in hospitals or similar institutions either as full-time employees or on a fee-for-service basis.

The greater part of the cost of professional health care (approximately 70%) is covered by a public insurance system under the General Law on special medical expenses and the Sickness Fund Law. The remaining 30% or so is covered by private insurance and direct payment.1

2.2 Lay initiatives

Alongside the professional care described above, the role of non-professional activities is growing. A recent study2 shows that such initiatives have generally arisen to supplement professional care where the latter has proved unsatisfactory. In the Netherlands, most patients’ organizations and self-help groups have come into being because existing care was considered inadequate or too limited in scope. A small number of them, however, have arisen as a reaction against professional care, which is considered by some to be threatening and to limit free choice by the individual. Organized lay activities in the area of health care are almost always of a curative nature and relate to a particular problem. Initiatives of this kind in the areas of prevention and health
promotion are generally launched by professionals or professional organizations.

In addition to group-organized lay activities, there is increasing interest in a healthy lifestyle and do-it-yourself health care. The “patients’ rights” movement also shows the way in which the Dutch people are attempting to substantiate their feeling that the existing health care delivery system needs to be changed. The sections below attempt to determine whether these various activities are directly or indirectly in conflict with the law.

3. Health legislation in the Netherlands

In the Netherlands, medicine may be practised only by persons legally licensed to do so. This provision was laid down as early as 1865, as in the interests of public health it was considered necessary to prohibit quackery. The central provisions are contained in Section 1 of the 1865 Law regulating the practice of medicine and Section 436 of the Penal Code. Since 1865, the Supreme Court, when issuing verdicts under Section 1 of the 1865 Law, has made specific reference to the following terms from that Section: “medicine”, “medical advice or assistance”, and “commercial practice”.

Section 436 of the Penal Code (“any person who, except in cases of necessity, practises a profession without being licensed to practise that profession where this is required by law shall be liable to a fine not exceeding one thousand guilders”) has given rise to various judicial interpretations of the term “except in cases of necessity”. A number of the interpretations given by the Supreme Court are described below. Although the following interpretations were issued in connexion with criminal proceedings against quacks (hypnotists, etc.), they are of relevance here because of the possibility of self-care being regarded as a penal offence if judgement is made on the basis of the same legislative provisions (taking account of the intentions of the legislator and present-day judicial interpretations).

“Medicine”

Attempts have been made to restrict the meaning of “medicine” (which under the 1865 Law means the rendering of general medical care, surgery, or obstetrics) to “official medical science” so that, for instance, care provided by hypnotists would not be included. However, the Supreme Court has rejected such attempts and has decided that the Law applies to the whole field of medical activities, whatever means are used and whatever method is applied.4

“Medical advice or assistance”

In a reply given by the Cabinet to the provisional report by the Parliamentary Committee on the 1865 Law, it is clearly stated that, in

International Digest of Health Legislation, 1981, 32 (1)
order for advice to be given, two persons must be involved. Thus, for example, a recommendation in an advertisement is not covered by the Law.

The Supreme Court has stated that "medical advice or assistance must be understood to mean every rendering of assistance with the intended or actual result of producing a curative effect upon the patient". Attempts to restrict this concept have led to the further pronouncements that "the Law does not require the person receiving advice to actually be ill", "the advice may also be given in the patient's absence", "... without an examination having been made", and "invocations for the healing of another person by prayer do not fall under the term 'rendering medical advice or assistance'".

"Commercial practice"

Whether commercial practice is involved is decided by the judge in the light of the facts of the individual case. This is clear from the following pronouncement by the Supreme Court: "It may be deduced, not merely from the multiplicity of acts performed at various times but also from other circumstances such as the receiving of payment, that medical advice or assistance has been rendered as a commercial business, and hence that medicine has been practised as a profession, for which purpose it is not necessary for the person performing the act to make such practice his profession."

"Except in cases of necessity"

Attempts have been made by unlicensed persons to persuade the Supreme Court that a case of necessity exists where the patient has already unsuccessfully sought help from a physician. Here the Supreme Court has ruled as follows: "The concept of necessity may not be extended to every situation in which a person suffering from a disease, handicap, or disorder has previously turned unsuccessfully to one or more licensed medical practitioners, as in that case it would be possible for any person henceforth to render medical advice or assistance to all those considering themselves or considered to belong to that category."

In various pronouncements, the Supreme Court has given the following definition of the concept "except in cases of necessity": "the words 'except in cases of necessity' are to be understood in the sense that at a certain moment, in a certain place, medical assistance is urgently required and in that place, at that moment, a legally licensed medical practitioner is not available".

From this brief review of judicial pronouncements, it may be concluded that self-care does not often come within the purview of the 1865 Law. In particular, the phrase "commercial practice", concerning which the judge is free to base his decision on the facts of the case at hand, can exclude a number of lay activities. It is also important to note that the Office of the Public Prosecutor follows a restrained policy.
of prosecutions and that, moreover, any sentence given is generally light. Furthermore, in the event of a prosecution concerning lay activities, the judge will take into consideration both the intention of the legislator and changes in society when passing sentence.

For the sake of completeness, mention should also be made of the 1963 Law on the allied health professions, whereby a number of allied health professions (such as physiotherapy) ceased to be illegal.

However, the foregoing does not mean that no urgency is felt in the Netherlands for legislative reform. A Bill which is currently being drafted, on the basis of the concept that each person should be able to seek treatment wherever he thinks fit, aims on the one hand to afford the public sufficient protection and on the other hand to protect various alternative healing professions from prosecution. It is not yet known which system will be followed.

Section 2 above gave an outline of the various health benefit schemes in the Netherlands and a short commentary on the way they are financed. Within the scope of this short article, it is not possible to give further details regarding the system of financing. For our purposes, it is important to know that social insurance legislation provides for the coverage of the costs of practically all treatment carried out by licensed professionals, ranging from long-term stays in nursing homes to treatment provided by general practitioners. As soon as a given profession achieves sufficient professional status (including an approved course of training), the social pressure to bring the treatment provided by the new profession under the general social insurance scheme is almost irresistible. As a result, there is little enthusiasm in the Netherlands for the activities of lay practitioners. Rather, there is considerable social pressure on the Government to provide more and more benefits backed up by professional qualifications and thus to bring them within the social insurance scheme.

4. Self-care, the law, and the welfare state

One of the characteristics of the welfare state is the continuous expansion of financial and other benefits designed to promote the health and wellbeing of certain categories or the whole of the population. This expansion occurs under continuous pressure from various social groups, who appeal to an extremely detailed system of legislative provisions that aim to bring about a fair distribution of welfare and guarantee the "right" to welfare and health. Owing to the complexity of the structure of regulations and benefits, the individual citizen is now paradoxically dependent on experts in order to effect his claims guaranteed by the all-providing state. To quote Schuyt: "In the welfare state, access to knowledge and information has perhaps become more important than access to money." The inherent specialization and bureaucracy of a welfare state results in fragmented and impersonal provision of services, causing feelings of alienation in the client. It is questionable whether the full
granting of patients' rights can sufficiently compensate for such feelings of discontent and alienation.

The same question arises in connexion with the growth of non-professional care as described in Section 2. What most organized lay initiatives (patients' organizations, self-help groups) have in common with pressure groups is that, in fact, they do not question the fragmentary (disease-oriented) approach adopted by health professionals.

The above remarks should not be taken to mean that we do not applaud the rise of lay activities and patients' rights. We are pleased to see that in the Netherlands self-care is not likely to be directly obstructed and that work is in progress on the official recognition of patients' rights.

However, as long as legislation continues to consolidate the dependent position of the citizen, events now taking place will remain no more than tiny steps in the right direction. If self-care, in the sense of independent responsibility for one's own health and the health of one's fellow human beings, is really to become a starting point for health care, then a fundamental rethinking of the present-day aims of our welfare state and the demands made on government and legislation is essential. Careful research into legislation will be necessary to explain, and if possible to resolve, the discrepancy between the expectations that have been raised and the existing feelings of disappointment and apathy.

Notes


3. Subsections 1 and 2 of Section 1 of the Law read as follows:

"1. (1) The practice of medicine, which under the Law means the rendering of medical, surgical, or obstetric advice or assistance in the form of commercial practice, shall be restricted to those persons authorized to do so under the Law.

(2) The rendering of advice or assistance, as referred to in the preceding subsection, shall mean the examination, on a commercial basis, of an organ or part of the human body which is functioning inadequately or displays some other infirmity, as well as the recommendation on a commercial basis of any means of alleviating such inadequacy or infirmity."

4. Supreme Court, 20 November 1911, W. 9240 C.V.
5. Supreme Court, 2 May 1938, N.J. 1938, 806.
7. Supreme Court, 24 June 1912, W. 9359, C.V.
8. Supreme Court, 10 March 1913, N.J. 718, W. 9475.

International Digest of Health Legislation, 1981, 32 (i)
Portugal

Contribution by
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This paper is intended to summarize the salient aspects of Portuguese legislation defining the scope of medical practice and to examine the possible implications, now or in the future, of self-care (the provision of oneself or one’s family with health care). In this connexion, it should be stressed that this analysis is not based on any feeling that there is currently a problem in Portuguese society with regard to the legal limitations on the practice of self-care, but rather on the wish to participate in a comparative study of the situation based on the experience of certain other countries, where this issue appears to be causing some concern.

The basic rule governing the provision of health care in Portuguese society is that the physician alone is competent, whether in matters of observation and diagnosis or in matters of treatment. Section 12 of Decree-Law No. 32171 of 29 July 1942 prescribes that:

Any person who, without any formal qualifications or without sufficient formal qualifications, carries out the observation or treatment of persons by any method or process designed to cure diseases or other ailments or any other act that is the prerogative of the medical profession, and any person who directs any of the acts referred to in this Section, shall be subject to the penalty prescribed in item 2 of Article 236 of the Penal Code [six months to two years’ imprisonment and a corresponding fine].

Thus, not only is any act designed to cure diseases or other ailments considered a crime, but so is any act that is “the prerogative of the medical profession”.

Perusal of the above provisions does not reveal any specific definition of the acts that are restricted to physicians; the legislator has opted instead for a general reference to acts that are “the prerogative of the medical profession”, an expression which does not by itself help to
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specify what those acts are. It relies on the well-rooted notion that the physician is the "health professional par excellence", and this idea is assumed a priori.

This lack of precision surrounding the definition of the exclusive competence of the physician is also apparent with regard to the competence of other health professions. For instance, nurses are licensed to carry out acts within their competence as determined by the relevant certificates and regulations governing the profession. However, this provision is of limited practical value, as the certificates and regulations in question are more concerned with defining working conditions from the administrative and disciplinary points of view than the area of competence of the profession.

Moreover, it is difficult to talk of the area of competence of the nursing profession in terms of the present law, since the latter prescribes that nurses are stepping outside their professional competence if, in cases other than emergencies, they carry out treatment other than under the direct instructions and supervision of a physician (item 2 of Section 14) or that nurses may provide patients only with those services indicated by the physician under whose actual instructions they are working (§1 of item 6 of Section 14). Such services, which are not specified in the law, may (on the instructions of a physician) also be provided by medical students, medical auxiliaries, or any person on the staff of a therapeutic establishment, without any specific professional training being required.

Thus, the competence of non-medical personnel to carry out acts intended to affect the state of health of persons is ultimately determined in each case by the physician who, as we have seen, may delegate such acts to any employee of a health establishment, at his own discretion.

Protection of life and health has been taken to its logical extreme by the legislator who, anxious to protect the citizen from the harmful illegal practice of medicine, has generally prohibited acts affecting the health of the individual and established the physician as its sole guardian.

A certain degree of autonomy in professional practice is granted to midwives who are legally required to immediately call in a physician only in cases of abnormal pregnancy, childbirth, or puerperium or miscarriage (§2 of item 6 of Section 14).

The practice of self-care, which has not received specific treatment under the law, is thus ultimately covered by the restrictive framework described above. In fact, the Portuguese legal system makes no specific provision for self-care and, even where lay persons are authorized to intervene in emergencies because a physician cannot be called in (§4 of Section 12), this is seen in terms of the emergency justifying action that is normally criminal, rather than as approving any type of self-care in the form of diagnosis or treatment by an individual of himself or others (whether or not they are members of his family).

In practice, the narrow limits laid down by the formal system described above have not been adhered to. The courts have frequently
acted to moderate the rigour of the law and reconcile it with the provision of health care by lay persons, provided that their intervention remains within reasonable limits as defined by criteria of morality, common sense, etc.

In a case of treatment involving the application of hot poultices and injections without remuneration, the Court of Appeal in Lisbon found that such treatment did not constitute illegal practice of medicine, on the grounds that the acts involved did not go beyond the limits of friendship or humanity and that illegal practice of medicine must involve profit-making intent (it should be noted here that the law does not specify this condition as essential for the act to be deemed criminal, although it is an aggravating factor).

The Court of Appeal in Porto found that a defendant who, without any profit-making intent and in a spirit of altruism and charity, performed intramuscular and intravenous injections without being qualified to do so was not guilty of illegal practice of medicine or, indeed, of any other offence.

Habitual practice has also been considered an essential element of the crime under the terms of Section 12 of Decree-Law No. 32171, and in numerous cases the courts have declared that a crime is involved only where the defendant has performed acts that reveal a certain degree of propensity.

The severity of the law varies in accordance with the seriousness of the consequences to the patient of acts performed by non-physicians that are the prerogative of the medical profession. Where the patient's health suffers damage, the penalty is the same as for deliberate physical injury (this may be from two to eight years' imprisonment, more severe penalties being applicable where the patient dies).

The cases that come before the courts generally involve illegal practice of medicine viewed as the practice of activities that are the prerogative of physicians and that involve other persons; they do not concern the concept of self-care as a health promotion activity, in other words self-diagnosis and self-treatment. Nor do such cases relate to health care dispensed to members of one's family.

Despite the still rather exploratory and essentially theoretical nature of the approach used, the documentation available to date suggests that the problem of possible incompatibility between self-care and the existing legal framework regarding the practice of medicine is not one that is currently preoccupying Portuguese courts. Moreover, even if such situations should arise in practice, it seems legitimate, at least in the present context, to hope that the moderating role of court findings, seen in judgements concerning violations of formal precepts, would come into play here with even more justification.

If, as we believe, the issue in Portugal is not so much how to deal with as how to prevent the legal problems of self-care, what measures would it be advisable to plan and carry out?

First of all, it would be useful to provide for more systematic procedures and to specify the information necessary in order to measure the

*International Digest of Health Legislation, 1981, 32 (1)*
extent of the problem and thus confirm (or otherwise) our conclusion regarding the actual significance of the problem in Portuguese society at present.

Subsequently, it would be necessary to carry out a coherent study on the apparent differences between our situation and that in other countries, particularly more developed ones. What are the factors in the Portuguese context that allow such an apparently flexible and adaptable application of a formal legal system which very possibly is no less restrictive than the legislation in other countries? A number of groups of factors which could explain this can perhaps be listed at this point:

1. legal factors associated with the nature of the legal system and the practice of Portuguese jurisprudence;
2. sociological factors with reference to conditions of access and relations between the community and the judicial system; and
3. factors associated with the system of provision of health care; in the case of Portugal, the following aspects should be stressed:
   3.1 the significance and the extension of the public sector of the health care system, in which administrative intervention is possible in addition to judicial intervention; and
   3.2 the almost total absence of involvement of insurance agencies in relations between the private practitioner and the user.

Thirdly, it would be useful to monitor trends in the legal cases involving self-care and in the factors most probably associated with it.

Finally, every effort should be made to place the issue of self-care in its proper context, which is that it is only one facet of a particular pattern of health care. It is difficult, and perhaps undesirable, to consider the problem of self-care in a given community aside from the issue of access to, and the nature of, health care, particularly with regard to its continuity and the role of health education, and the factors that encourage each individual to participate in and take responsibility for solving his own problems.

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**Sweden**

*Contribution by Kay Gunnar Wilow, Lars Hultstrand, and Ulf Nicolausson*

In their article, Andrews and Levin present a survey of United States legislation governing the right to practise medicine, and discuss the effects of such legislation upon the practice of non-professional self-care by the individual. The very title of the article ("Self-care and the
The problems described by Andrews and Levin conceivably arise out of the structure of the various laws on medical practice now in force or, to be more precise, out of the fact that the legislation on the one hand defines the practice of medicine and on the other limits its practice to licensed persons. A literal interpretation of the provisions of such legislation could lead to astonishing conclusions: for instance, it might prohibit a parent from administering cough syrup to a child, or exclude a father-to-be from the delivery-room. Clearly, the area left for lay medical practice in the United States is, at least on paper, extremely limited.

Before embarking upon a discussion of how self-care, in the wide sense described above, is regulated under Swedish law, it may be useful to describe how Swedish legislation comes into being and how medical care is organized in Sweden.

Legislation is normally initiated by the Parliament (the Riksdag), and all public regulations that significantly affect the individual must take the form of legislation. The Riksdag can delegate certain powers to the Government, for instance the power to issue detailed regulations on the protection of the health of individuals. The Government is likewise empowered to lay down provisions for the implementation of the laws passed by the Riksdag, and can in turn transfer its powers to public bodies such as the National Board of Health and Welfare.

Health care delivery is regarded in Sweden as being clearly a task for the public sector, and is provided mainly through the local authorities. Responsibility for individually-oriented health services and for inpatient and outpatient medical care lies with the 23 county administrations and three independent municipal administrations. Nearly all major hospitals and all health centres are administered by these authorities, which also operate the public dental service, covering all children up to the age of 16 and providing a certain amount of adult dental care as well. Mental health care is also the responsibility of these authorities. On the other hand, social welfare services and public health (environmental health) are administered through the municipal authorities, of which there are currently about 275.
Private health care is available on a limited scale. Only 5% of Sweden's physicians are in private practice, and these are mainly found in the major cities. However, the corresponding figure for dentists is over 50%. There are only a small number of private medical care institutions within the inpatient sector (chiefly private nursing homes for long-term care).

Medical care in Sweden is thus organized in such a way as to ensure that everyone should have access to proper care in the event of illness or accident. Indeed, the Medical Care Law requires the county or independent municipal authorities to provide such facilities as are necessary in order to meet the medical and dental care needs of persons living in their area, and this requirement also extends to the immediate needs of persons visiting the area.

The activities of each of the authorities in the health care field are directed by a special board. Lay representation on these boards is required by law, which takes account of the natural concern of the general public to keep abreast of and influence the running of health services. Lay representatives are democratically elected.

Although, in many respects, the local authorities operate their health-care delivery systems independently, the State retains supervisory powers over their activities. In particular, it must ensure that political decisions regarding health care are duly implemented and that all persons have equal access to high-quality care throughout the country, according to their needs. For this reason, medical care is supervised by the National Board of Health and Welfare on behalf of the State.

The Medical Care Law in its present form does not prohibit lay persons from practising medicine, nor does it restrict the right to practise to licensed persons. This is, in fact, not surprising, as the Law is intended only to regulate the organization of health care and, above all, the obligations of the local authorities in this respect. However, this does not mean that any person can practise unhindered and claim to be a qualified physician, nurse, physiotherapist, etc. Under the terms of a 1960 Law, only those persons licensed by the State (in other words, by the National Board of Health and Welfare) or duly appointed as a locum tenens are permitted to practise medicine. Similar regulations apply to dentists and midwives. Nurses, physiotherapists, psychologists, and opticians, on the other hand, may practise without a licence provided that they do not then claim to be licensed.

It is, of course, essential that all health personnel are properly trained and perform their tasks with the necessary skill and to the best of their ability. Accordingly, a course of training is laid down for each of the professions referred to and must be followed by any person wishing to practise that profession. Moreover, all categories of health personnel working under the supervision of the National Board of Health and Welfare are subject to the relevant disciplinary provisions. There is an independent board (the Health and Medical Care Liability Board) that deals with cases of alleged malpractice. Health workers found guilty of negligence, misjudgement, or incompetence in their professional prac-
tice or of being significantly ignorant of the regulations to which they are subject may be given a reprimand or a warning or be recommended for trial by a court of law. The Board can also revoke licences. Naturally, cases subject to public prosecution are tried before ordinary courts of law.

What, then, does the right to practise medicine imply? For instance, are there any examinations, types of treatment, etc. that only licensed physicians may perform? The answers to these questions are partly found in the General Instructions for Physicians issued in 1960. These state that every physician must, in accordance with scientific knowledge and established experience, provide patients with the advice and, where possible, treatment the patient's state of health requires. In addition, a number of activities are restricted to physicians, such as the prescribing of medicaments (this right is extended to dentists and certain midwives under limited conditions) and the issuance of certain certificates. However, the area of medical practice can be defined more precisely by referring to the content of medical training courses. The particular areas of competence of nurses, midwives, assistant nurses, dentists, physiotherapists, etc. can likewise be determined by examining the relevant courses of training in combination with the provisions of certain legislative texts.

Any health worker who performs a medical service outside his own area of competence or neglects to act in accordance with scientific knowledge and established experience is liable to be disciplined by the Health and Medical Care Liability Board, whose decisions are clearly of great importance to the practice of the health professions.

We have now outlined the basic features of the Swedish health-care delivery system, and some of the more important rules governing the practice of medicine. So far, we have not referred to any regulations prohibiting the practice of self-care. However, regulations of this kind are found in the 1960 Quackery Law. This Law regulates the extent to which and the conditions under which persons who are not health workers may practise medicine in Sweden.

In order to understand the Swedish attitude towards the practice of medicine by lay persons, a brief historical review is necessary. However, it is not necessary to go any further back than the beginning of this century. Sweden, with an area of some 450 000 square kilometres, is one of the largest European countries. It was then, and is still, sparsely populated. By today's standards, the communications system was scarcely developed, and there was a marked lack of qualified physicians. Thus, for people who lived in the country it was difficult to get hold of a physician when needed. In most cases, therefore, people were forced to help themselves as well as they could in cases of illness, childbirth, etc. — as they had done for generations. Otherwise, they could turn to members of their family, neighbours, or friends, or to a natural healer (the nearest "wise" old man or old woman). There was thus a long tradition of folk medicine in Sweden.

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distinguish clearly between qualified medical practice and quackery. In any event, the first law on the licensing of medical practice did not appear until 1915. This law prescribed that any person wishing to practise medicine had to be licensed by the Royal Medical Board, but there was no provision expressly prohibiting other persons from practising medicine.

This law drew a boundary between licensed and unlicensed medical practice, but the area left to unlicensed medical practitioners was a large one. However, there were restrictions: unlicensed physicians were not allowed to treat venereal diseases, tuberculosis, cancer, or certain infectious diseases, and were further prohibited from treating others by means of hypnosis or under general anaesthesia. The penalty in such cases was a fine or up to one year’s imprisonment. The courts were also entitled to fine unlicensed practitioners who endangered the health or life of their patients through their treatment.

During the 1940s and 1950s, the regulations governing the practice of medicine and restricting the activities of unlicensed practitioners were the subject of a vigorous debate. The main issue was this: was there now any good reason to allow such extensive scope for unlicensed medical practice to continue? As early as 1941, the Royal Medical Board suggested that the rules governing quackery should be tightened up, without however recommending total prohibition. However, no immediate action was taken by the Government or the Riksdag. In 1950, a special committee was set up to study the question of unlicensed medical practice and related matters. The committee’s proposals, submitted in 1956, were that the practice of medicine should not be restricted solely to licensed practitioners. The Government and the Riksdag decided to adopt the general principle that any person should be entitled to practise medicine, but subject to certain conditions. This was the basis for the above-mentioned Quackery Law.

This law does not apply to physicians or other persons whose professional practice is subject to supervision by the National Board of Health and Welfare (in other words, to health service personnel). Such personnel are governed by the legislation referred to earlier. It may therefore be said that, in Sweden, the State has acknowledged the existence of two separate branches of medical practice, one based on medical science and restricted to health service personnel, and one that is unorthodox and is open to lay persons.

The provisions of the Quackery Law apply to persons other than health service personnel who examine or treat other persons for gain with a view to preventing, curing, or alleviating diseases or ailments. This is true irrespective of whether the treatment has any intentional or unintentional effect upon the patient’s state of health. It should be noted that these provisions also apply to general advice on how to preserve good health.

The “for gain” criterion means that anyone is free to treat himself medically in whatever way he wishes — in other words, the right of the individual to choose his own treatment is in no way called into ques-
tion. The individual is also permitted to treat members of his family or his friends, or in fact anyone else, provided that he does so without charge. It is thus not an offence, for instance, for a member of a medical aid group to advise any other member of the group or any other person, without charge, on how to treat a certain disease.

Under the provisions of the Quackery Law, lay persons may not: (a) treat certain epidemic diseases, tuberculosis, venereal diseases, cancer, diabetes, epilepsy, or pathological conditions associated with pregnancy and childbirth; (b) examine or treat children under eight years of age; (c) issue written advice or directions concerning the treatment of a disease without having personally examined the patient; (d) examine or treat any person under general or local anaesthesia or hypnosis; or (e) treat any person by radiological methods. The National Board of Health and Welfare has also recently proposed an amendment which would prohibit lay persons from fitting contact lenses.

Only Swedish citizens may practise medicine without a licence in Sweden. A further restriction is that itinerant practice is prohibited.

The Swedish legislator considers it important to protect the consumer from buying goods or services under false descriptions. For instance, a patient who consults a physician must have a guarantee that the person treating him is really a licensed physician. Consequently the title of "physician" in the sense of a licensed physician may not be used by anyone else. Thus a lay practitioner may refer to himself as a physician, but only if he specifies the true nature of the qualification (e.g. doctor of chiropractic) and its origin in his advertisements, telephone directory entries, etc. He may not use the title of physician in a manner that gives the impression that he is licensed.

Persons who violate the provisions of the Quackery Law or cause injury or a risk of injury through their examination or treatment are liable to a large fine or imprisonment. In this connexion, there is deemed to be a "risk of injury" if, for instance, treatment by a lay practitioner results in the patient consulting a licensed physician too late to receive proper care. Where a person has been convicted of quackery resulting in danger to the health of the patient, the National Board of Health and Welfare may then prohibit him from practising, either temporarily or permanently.

In conclusion, the law in Sweden makes provision for self-care, but restricts unlicensed medical practice in order to minimize the risks involved. The authorities acknowledge that such activities exist, and the Quackery Law is designed to prevent serious consequences. However, the provisions of the Law do nothing to prevent the social and economic damage resulting from lay practitioners attempting to make a commercial profit out of people's health problems. There would seem to be a need for information from the health authorities concerning the effects of the methods used by lay practitioners.

On the other hand, it is clear that treatment by lay practitioners does sometimes influence the patient's state of health. Whether or not this influence is due "merely" to psychological factors, there is good
reason to investigate such unorthodox methods. The National Board of Health and Welfare has therefore declared that it is not opposed to such investigation or scientifically sound research activities in fields such as acupuncture, chiropractic, and naturopathy. Indeed, the Board has now undertaken an evaluation of chiropractic, with financial support from the Government. Under this project, chiropractors are authorized to work in collaboration with licensed professionals in certain orthopaedic clinics, and the results of this collaboration will eventually be evaluated. There are also a number of scientific projects on the effects of various forms of acupuncture.

It may seem from the above that the Swedish Quackery Law satisfactorily deals with the problems of unlicensed medical practice. In fact, however, the provisions of the Law are not always easy to interpret and apply, and may need some revision. For instance, the Law gives no clear indication as to whether a given medical act outside the area of competence of a physician, nurse, midwife, etc. is to be regarded as quackery or not.

Switzerland

Contribution by Theodor Abelin

Cantonal autonomy in matters of health

Switzerland is a Confederation of 26 cantons with a population of 6.3 million. Except in a few areas explicitly identified in the Federal Constitution, the cantons are autonomous in matters of health. The exceptions are principally in areas historically related to the police sanitaire approach to public health, which necessitates uniform regulations and penalties; examples are water and air pollution control, radiation protection, dealings involving poisons, food hygiene and safety, narcotics control, and the control of communicable diseases. The practice of the health professions, on the other hand, is regulated at the cantonal level; some of the legislation here dates back to the 19th century, and some clearly reflects the provincial character of the populations involved.

Regulation of the practice of the "academic" health professions

Section 33 of the Federal Constitution leaves the cantons free to determine whether the practice of the "academic" professions (medicine, dentistry, veterinary medicine, and pharmacy) is to be subject to an officially recognized qualification. However, the same Section requires provision to be made at the Federal level for a system of

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diplomas for these professions that is valid throughout the Confederation. Accordingly, there are Federally-regulated examinations for diplomas in medicine, dentistry, veterinary medicine, and pharmacy, and faculty curricula in these areas are designed to meet Federal requirements. Individual cantons may not lay down more stringent requirements than those contained in Federal legislation. In other words, the cantons are given an opportunity to lay down high standards of academic competence for physicians, but are also free to allow less highly trained healers to practise.

In the event, all of the cantons have elected to require "academic" health professionals to be holders of a Federal diploma. In most cantons, exceptions are made for areas where the number of physicians or dentists is extremely low, and in such cases holders of foreign diplomas may also practise. Of interest for the purposes of this study is the fact that two cantons (see below) regularly authorize practice by healers who have no academic training.

Regulation of the practice of the "non-academic" health professions

Regulation of the practice of the "non-academic" health professions (nursing, midwifery, chiropractic, massage, physiotherapy, speech therapy, and orthopaedics) is entirely the responsibility of the individual cantons. However, in 1976 the cantons delegated the task of regulating training in a number of these allied health professions to the Swiss Red Cross (a private, non-profit-making organization officially acknowledged to be acting in the public interest). Where uniform standards have not been laid down by the Red Cross or other professional organizations for particular professions, the cantons have their own regulations. In general, appropriate physical and mental capacity and a certificate of good character are minimum requirements for the practice of any health profession. Exclusion from practice on religious grounds is prohibited under the Federal Constitution but where practices damaging to health arise from religious beliefs, the authorities may intervene under penal law. Most of the cantons define the health professions that require official diplomas in accordance with the usual international standards, but exceptions are found in three cantons. In one, a non-medical acupuncturist was licensed to practise several years ago, but so far this has remained an individual exception. In the other two cantons, the law makes explicit provision for the practice of lay healing. In the Canton of Basel-Land (220 000 inhabitants), lay healers must pass a Government examination, and the healing methods authorized are fairly limited. In the rural Canton of Appenzell Ausser-Rhoden (50 000 inhabitants), however, the Law of 25 April 1965 on health permits lay healing by any resident of the Canton, except in the following areas: surgery; treatment of notifiable communicable diseases (other than influenza) and sexually transmitted diseases; injections, punctures, and infusions; the use of "fraudulent methods"; and other functions specified from time to time under the Law. In certain cases, such as the ad-
ministration of injections, exceptions may be made. As a consequence, this small mountainous area of north-eastern Switzerland has become a notorious centre for non-medical healing practices.

In a number of other cantons, non-medical healing is also widely tolerated provided that no charge is made for services rendered. Charging for services is considered as the criterion which defines professional practice, and thus lay healing is classified as a variety of self-care provided that remuneration is only by way of gifts.

**Regulation of self-care**

A prevailing political principle in Switzerland is that the greatest possible freedom and responsibility should be left to the individual provided that undue harm to others is avoided. This is especially true in the area of health, and theoretically provides a good basis for responsible self-care. Under this principle, self-care falls within the rather large area of non-regulated aspects of life. Provided that no charge is made and that harm to others is avoided, there is no legal restriction upon self-care and care of relatives or friends, except under welfare and penal legislation (negligence of parental or guardianship duties, or danger or damage to bodily integrity). The same principles apply to the teaching of self-care practices.

**Preventive self-care**

Provided that there is no risk of harm, Swiss health legislation does not restrict commercial offers in the areas of prevention, health preservation, and health promotion. Thus not only preventive self-care but also critical evaluation of the many goods and services advertised in this area are left to the responsibility of the individual. While intercantonal regulations on pharmaceuticals prohibit general advertising for prescription-only medicaments and other medicaments that constitute a health risk as defined by the Intercantonal Office for the Control of Medicaments, the sales promotion of most ingestible preparations and other products stated to be for preventive use is regulated only by commercial legislation.

**Health insurance and self-care**

Health insurance in Switzerland is regulated by Federal legislation. Reimbursement is provided for in the case of medical treatment, therapeutic activities by officially recognized auxiliary personnel under the instructions of a physician, and treatment by certified chiropractors. Recognition of auxiliary personnel is subject to evidence being provided that they have undergone the appropriate training. The non-profit-making health insurance companies operating under this legislation are free to offer additional coverage, but none is known to cover self-care or care by relatives lacking appropriate professional training.
Conclusion

Health legislation in Switzerland is designed not so much to promote good health as to protect the citizen from bodily harm, particularly that caused by improperly trained health personnel. Similarly, health insurance legislation is scarcely determined by public health considerations, but rather by actuarial principles. Such a relatively restricted conception of the role of the State in matters of health evidently does not include support of the individual in meeting his responsibility for his own and his family's health, or incentives to promote self-care and the care of sick or disabled relatives or friends. Although in most cantons the practice of lay healing is prohibited, and although Federal legislation makes provision for the maintenance of high standards of technical competence within the medical professions, individual citizens are largely left to their own devices when it comes to choosing from the wide range of health promotion products on offer. Consideration is now being given to the introduction of Federal legislation designed to tackle more effectively the aspects of prevention and, in particular, health education, but political discussions so far suggest that increased concern for public health will not easily prevail over such well-established principles as cantonal autonomy in matters of health, freedom of trade, and minimization of State intervention.

Acknowledgments

I would like to thank Mr H. Kelterborn, Legal Service, Swiss Federal Office of Public Health, and Mr R. Kübler, Central Secretary, Conference of the Directors of Cantonal Health Departments, for the detailed information provided, and many other persons for their valuable comments.

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   (b) General Medical Professions Examination Ordinance of 19 November 1980 (subject to approval by the Federal Parliament).
   (c) Ordinance of 19 November 1980 on examinations for physicians (subject to approval by the Federal Parliament).
   (d) Ordinance of 19 November 1980 on examinations for dentists (subject to approval by the Federal Parliament).
   (e) Ordinance of 19 November 1980 on examinations for veterinarians (subject to approval by the Federal Parliament).
4. The professions concerned are: Basic training — general nurse, psychiatric nurse, paediatric nurse, practical nurse, medical laboratory technician, midwife, dietician; Supplementary training — e.g. public health nurse, practical community nurse; and Staff training — e.g. ward nurse, director of nursing, nursing instructor.
8. Federal Law of 13 June 1911 on sickness and accident insurance (items 1(a), 1(b), and 1(e) of subsection 2 of Section 12).
9. Ordinance No. VI of 11 March 1966 on sickness insurance with regard to the licensing of auxiliary medical personnel to practise under the sickness insurance scheme.