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Registration of Health Professionals in the United Kingdom and Botswana: A Comparative Analysis of the Overarching Principles

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Abstract

This article assesses the laws governing the registration of health professionals in Botswana and compares them to those in the United Kingdom (UK). It discusses the legal framework concerning the overarching functions of regulatory bodies and the governance arrangements in both jurisdictions. In the UK, the registration of professionals has advanced significantly since the 18th century, while it remains in its early stages in Botswana. The primary intention of the law is to protect the public as users of health services, as such provisions represent a public good. The article examines several leading cases in health registration and emphasises the need to safeguard the public without disadvantaging professionals. The primary sources of law in the UK and Botswana are explored, alongside the healthcare regulation laws of other countries, including those in the Southern African Development Community.

Keywords

health professionals, registration, health regulation, practice licensing, health law, comparative law

1. Introduction

1.1 Problem statement

Health care professional services constitute a Human Resource for Health building block of a health care system, according to the World Health Organization (WHO) Framework of Health Systems.[1] Similarly, Regulatory Frameworks constitute a Governance/ Stewardship building block of the same framework.[2] As key components of the health system, it is emphasised that assuring the public of a qualified, ethical and consistent professional workforce through clearly defined regulatory provisions is a fundamental role that countries must fulfil. Countries such as the UK and Botswana that are being

1 Manyazewal, T 'Using the World Health Organization Health System Building Blocks through Survey of Healthcare Professionals to Determine the Performance of Public Healthcare Facilities' (2017) *Archives of Public Health* 75.

2 Ibid.

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compared here, must provide a registration framework for professionals. The framework must have a common platform that assesses the professionals. In comparing Botswana and the UK, this article presents the overarching principles of the registration of professionals. These principles: having clear legislation, setting educational requirements, determining common disciplinary standards and providing redress when there are lapses, aim to ensure safety.

Without clear registration frameworks, inconsistencies in patient care can arise, which may lead to a lack of trust in the health care system. Licensing procedures and requirements differ in several European Union (EU) countries, with a possibility of non-uniformity in some countries.[3] The status of the registration laws in the UK and Botswana is presented, and lessons are drawn from these nations.

1.2 Health profession registration in 2025 and beyond

Much has been said about the need for regulation. Conover indicates that regulation is a significant and costly hidden tax.[4] The article argues that it has both advantages and disadvantages. Its benefits include controlling who provides care to ensure that the public receives safe services. Among its challenges are the high costs associated with compliance with regulatory requirements. This article presents common themes in the case law of both countries. An assessment of the case law regarding registration reveals common decisions: the importance of maintaining confidence in the professions, protecting the public, and ensuring the safety of the health industry. It has been maintained that health profession regulation is influenced by the relationship between society, government, and the professions; the growth of health profession regulation; the internationalisation of health profession regulation; and the pressures of labour and skill-mix reform on health profession regulation.[5] It can therefore be inferred that health profession regulation through registration is advancing.

As the public health system advances with unlimited access to information, professional regulation must meet increased expectations. These public expectations require responsive and consistent regulatory frameworks and court decisions. In addition to heightened expectations, health professionals, educational institutions, and professional regulators must be accountable to the public in all processes. Advancements in human rights over the past two decades and the reduction of paternalism by professionals have contributed to the amplified voice of the public. This article assesses experiences from these two nations and presents an opportunity to identify commonalities and lessons. In professional regulation, particularly the mandatory registration of professionals to practise, proponents of registration have argued that the benefits of registration far outweigh the deleterious effects of not registering. One article indicates that registration exists under the

3 Kovacs, E, Schmidt, AE, Szocska, G, Busse, R, McKee, M & Legido-Quigley, H 'Licensing Procedures and Registration of Medical Doctors in the European Union' (2014) 14(3) *Clinical Medicine* 229.

4 Conover, CJ 'Health Care Regulation: A $169 Billion Hidden Tax' (2004) *Policy Analysis* 527.

5 Walshe, K 'Regulating Health Professionals' in Dugdale, P(ed) Patient Safety First (Routledge 2020) 144.

statutory function to protect the public interest.[6] The notion of the public interest will be discussed as an important impetus for professional registration.

With regard to health professions, the registrants (health professionals) deal with clients at their lowest point of need, when they request health services. Hence, it is imperative that the skills, education and calibre of the professionals are assured by a well-laid registration process.

2. The legislative frameworks for health profession registration in the UK and Botswana

2.1 Legislation

According to section 1(1B) of the UK's Medical Act of 1983, the overarching functions of the General Medical Council are:

> (a) to protect, promote and maintain the health, safety and well-being of the public.
>
> (b) to promote and maintain public confidence in the medical profession, and
>
> (c) to promote and maintain proper professional standards and conduct for members of that profession.

Likewise, section 4(1) of the Botswana Health Professions Act 17 of 2001 sets the primary objectives of the Botswana Health Professions Council as:

> (a) to promote the highest standards in the practice of health care in Botswana; and
>
> (b) to serve as a safeguard in protecting the welfare and interests of the public of Botswana in the practice and delivery of health care.

The common feature of professional regulation laws in the two nations is that the laws often stipulate that a person should not practise in a jurisdiction unless he or she is registered with a competent body. Provisions are made for maintaining a register of professionals, registering them in different categories, and instituting criteria for registration, including the categorisation of where these practitioners qualified. These provisions are common to the Acts governing chiropractors, nurses, midwives and dentists in the UK. Similarly, section 7 of the Botswana Nurses and Midwives Act 1 of 1995 provides for registration, maintaining a register, and penalties for those who practise without being registered or who contravene ethical standards. Greenberg[7] indicates that registration and investigation, when there is concern about a doctor, are used to ensure public safety.

Statutory professional self-regulation (SPSR) is the modality of regulation for health professionals in many jurisdictions, including Botswana and the UK. The main advantage

6 Leslie K, Demers C, Steinecke R & Bourgeault, IL 'Pan-Canadian Registration and Licensure of Health Professionals: A Path Forward Emerging from a Best Brains Exchange Policy Dialogue' (2022) 18(1) *Healthcare Policy* 17.

7 Greenberg, D *Doctors' Regulation* (Westlaw Practice Notes 2020).

of SPSR is that the professionals themselves set the expected standards of care. Often, laws are enacted to guide what self-regulation should occur. In the UK, the Medical Act, 1983 and the Dentists Act, 1984 are two such statutes that enable the self-regulation of medical doctors and dentists respectively. In terms of the Health and Social Care Act, 2008, a total of ten self-regulatory councils are given oversight by the Professional Standards Authority, a regulator of health professionals' regulators. In Botswana, the Nurses and Midwives Act 1 of 1995 and the Botswana Health Professions Act 17 of 2001 established two semi-autonomous regulatory bodies that use SPSR. These respectively regulate nurses, including midwives, and more than 25 health professions including doctors, dentists, pharmacists and physiotherapists. The Botswana Health Professions Act repealed the Medical, Dental and Pharmacy Act 10 of 1967; the updated Act allowed for inclusion of other professions presenting them as regulated health professions. These professions included the allied health and associated professions, such as physiotherapy, optometry and chiropractors. There are more than 25 professions, as detailed in Schedule B of the Act. The Botswana Nurses and Midwives Act repealed the Nurses and Midwives Act 43 of 1964, to regulate the nursing and midwifery professions.

2.2 Health profession registration laws: Institutional framework

There is a clear difference between the institutional frameworks of the regulatory councils in Botswana and the UK. In the UK, the regulatory bodies are independent statutory bodies, given powers by their relevant Acts. They are financed by the subscription fees of members.[8] Section 3 of the General Optical Act, 1989 establishes the General Optical Council, a regulatory body that regulates opticians as a body corporate. All the other regulatory bodies have juristic personalities, making them independent. The regulatory bodies have the power to appoint committees that have specific functions; some of the committees are statutorily required and established in terms of the statute. For example, the General Medical Council's Investigation Committee investigates matters of fitness to practise, and section 35D of the Act establishes the Medical Practitioners' Tribunal Service (MPTS), which adjudicates issues of fitness to practise.

The Botswana Health Professions Council and the Nursing and Midwives Council of Botswana function under a precarious arrangement. While the bodies are constituted by the members of the professions,[9] the Councils are fully funded by the government of Botswana through the Ministry of Health, and their Secretariats come from the Ministry.[10]

2.3 Overarching roles of the law

In both the UK and Botswana, the laws regulating the health professions, in relation to registration, aim to ensure public safety. In the UK, the laws use 'impairment of fitness to practise' as the criterion to de-register health care professionals. The laws provide for

8 World Health Organization 'Health Systems and Policy Monitor: United Kingdom England: Regulation' (2017).

9 Nurses and Midwives Act, 1995, s 3 and Botswana Health Professions Act 17 of 2001, s 3.

10 Botswana Ministry of Health Registration of Professionals <https://www.gov.bw/accreditation-professionals/registration-private-health-professionals> accessed 19 February 2025.

committees that conduct the assessments to determine impairment of fitness to practise. For example, the UK's Nursing and Midwives Order of 2001 provides for the Nursing and Midwifery Council's Conduct and Competence Committee and a similar body in the General Medical Council is the Medical Professional Tribunal. After establishing impaired fitness to practise, both panels are required to undertake a proportional process to determine the appropriate sanction.[11] This concept is not enshrined in the Botswana laws. Section 14 of the Health Professions Act provides for disciplinary measures and allows the Council to:

> enquire into any complaint, charge or allegation of improper or disgraceful conduct of a professional nature brought against any practitioner, and if it is satisfied that such complaint, charge or allegation has been proved, it may impose such penalty as it considers appropriate.

Such penalties include a reprimand, suspension or the cancellation of registration.

3. Case law

3.1 Case law in the United Kingdom

The courts have decided cases on the registration of health professionals in the UK, providing common principles. In *General Medical Council v Chandra*,[12] the Court of Appeal assessed Dr Chandra's plea to be restored to the medical register, after he had been struck off the register for professional misconduct. The court held that, in considering registration or restoration to the register, the Medical Fitness to Practise Tribunal must determine if the practitioner can practise safely and whether remediation has occurred in his or her conduct. The same is expected when initially registering the professional.

Similarly, in a case of restoration to the nursing register, *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Paula Grant*,[13] the Council appealed against a decision of the first respondent, the Nursing and Midwifery Council, that the second respondent, a registered nurse and midwife, was guilty of misconduct but that her fitness to practise was not impaired. The nurse was investigated and a hearing was held by the Nursing and Midwifery Council's Conduct and Competence Committee. The charges were that the nurse failed to assist a junior colleague, subjected that colleague to bullying and harassment for reporting her, and failed to provide appropriate care to patients on more than two occasions. The committee found that the charges were proved and amounted to misconduct. The committee referred to the judgment in *Cohen v General Medical Council*,[14] and found that the nurse's attitude had improved and that she had addressed her poor performance, so her fitness to practise was unimpaired.

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11 Hodson, N 'Regulatory Justice Following Gross Negligence Manslaughter Verdicts: Nurse/Doctor Differences' (2019) *Nursing Ethics* 250.

12 *General Medical Council v Chandra* (2018) EWCA Civ 1898.

13 *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Paula Grant* (2011) EWHC 927 (Admin).

14 *Cohen v General Medical Council* (2008) EWHC 581 (Admin).

The Council appealed under section 29(4)(b) of the National Health Service Reform and Health Care Professions Act, 2002, arguing that the committee's decision was unduly lenient. The Council contended that the committee had misinterpreted the decision in Cohen and failed to consider the need to regard public interest when determining whether fitness to practise was impaired. The court ruled in favour of the Council, stating that the committee had not mentioned the significance of broader public interest considerations or the necessity of giving substantial weight to protecting the public, maintaining public confidence in the profession, and upholding proper standards of conduct and behaviour. The law is therefore clear that the overarching goals of the Act take precedence in registration matters.

The main aim of the Acts, ensuring public safety, was a major factor in other UK cases. *Davies v Health Care Professions Council*[15] buttressed the importance of the public interest principle – that the main objective of registration is to ensure that the decisions of regulatory bodies protect the public and that professionals deliver safe care. *Adeogba v General Medical Council*[16] had earlier indicated that, in making their decisions, a regulatory tribunal must be guided by the main statutory objectives of the regulator and that the regulator's default position is being a representative of the public interest. *Professional Standards Authority v Health and Care Professions Council and Ajeneye*,[17] posited that the purpose of sanctions is not only to punish the individual, but to maintain the standards of health professionals. This was reiterated in *Ghaffar*,[18] where the court held that the primary objective of registration or sanctions is to protect the public from the potential risks posed by the registrant.

It does not always go to the side of punishment or sanction and judgements can pronounce non-punitive remedies In fact, Courts have also allowed registrants to be permitted registration on presentation of the improvement of the practitioner, as shown in *McDermott v Health and Care Professions Council*.[19] Such observation was also presented in *Khan v General Pharmaceutical Council*.[20] The court held that Mr Khan's conduct did not relate to his professional performance, and that no patient had been, or was likely to be, put at risk. The court held that the tribunal had fairly noted several features of the case which militated against the removal of his registration, such as his genuine acknowledgement of fault and the positive reports of his response to the requirements of the community payback order. Public confidence and safety are thus paramount factors in registration and fitness to practise.

In *R (on the Application of Patel) v General Medical Council*,[21] the appellant contested the General Medical Council's decision not to consider his primary medical qualification

15 *Davies v Health and Care Professions Council* (2016) 1 EWHC 1593 (Admin).
16 *Adeogba v General Medical Council* (2010) EWCA Civ 162.
17 *Professional Standards Authority v Health and Care Professions Council and Ajeneye* (2010) EWHC 1237 (Admin).
18 *Health and Care Professions Council v Ghaffar* (2014) EWHC 2723 (Admin).
19 *McDermott v Health and Care Professions Council* (2017) EWHC 2899 (Admin).
20 *Khan v General Pharmaceutical Council (Scotland)* (2016) UKSC 64.
21 *R (on the application of Sailesh Patel) v General Medical Council* (2012) EWHC 2120 (Admin).

as an 'acceptable overseas qualification', in terms of section 21B(2) of the Medical Act, 1983. He had studied his medical degree via distance learning but had completed most of his training attached to facilities in the UK. To ensure credible overseas qualifications, the General Medical Council (GMC) had set out a criterion in the definition of 'acceptable overseas qualification' that:

> [the qualification] must not have involved a programme of study where more than 50% of that study (compared to the standard duration of the qualification) has been undertaken outside the country that awarded the qualification.[22]

In this case the appellant had contravened this provision having completed more than 50% period of study in 2010 outside the country of award. Subsequently, the appellant's qualification was not recognised when he completed it in 2012. The overarching need for public safety played a role in the judgment. Furthermore, the decision of the GMC to review the criteria and include the above criterion was viewed as a means to ensure public safety.

In *Das v General Medical Council*,[23] the Privy Council heard an appeal by a general medical practitioner whose registration had been suspended following an investigation into his fitness to practise. An investigation into the doctor's professional skills had revealed that the practitioner was incompetent in many aspects, to the extent that the panel concluded that his clinical proficiency was seriously deficient. The practitioner did not appear at the GMC's hearing of the Committee of Professional Performance, and appealed the decision to endorse the suspension in his absence as a contravention of the provisions of Schedule 1, Article 6 of the Human Rights Act 1998, which provides for the right to natural justice. The evidence submitted showed that the practitioner had received several invitations to attend the hearing. In dismissing the appeal, the Privy Council observed that the evidence presented about his professional deficiencies was clear and detailed, and showed that his performance could be remedied only by retraining and that his suspension was necessary to protect the public.

In *Sandler v General Medical Council*,[24] pertaining to registration or deregistration, Lord Walker of Gestingthorpe summed up the rationale of the law regarding any sanctions: it is not to punish the professional whose professional performance is defective, but to improve standards and, in the process, to protect the public from risk. The same was held in *Dad v General Dental Council*,[25] where a dentist had his registration suspended for several violations of the Road Traffic Act, 1988 – driving while disqualified and reckless driving. His appeal was allowed and the court held that his suspension from practice should be withheld for two years, allowing ample opportunity for the appellant to demonstrate his ability not to re-offend. The principle of public interest and patient safety was upheld in *Dad* and taking judicial ground of *Ziderman v General Dental Council*.[26] The rationale in *Ziderman* was that 'disciplinary proceedings against a professional who has been convicted

22 Ibid.
23 *Das v General Medical Council* (2003) UKPC 75.
24 *Sadler v General Medical Council* (2003) UKPC 59.
25 *Dad v General Dental Council* (2000) 1 WLR 1538.
26 *Ziderman v General Dental Council* [1976] 2 All ER 334.

of a criminal offence by a court of law is not to punish him a second time for the same offence but to protect the public who may come to him as patients and to maintain the high standards and good reputation of an honourable profession'.[27]

3.2 Case law in Botswana

Cases have challenged the institutional arrangement of regulatory councils by the government, in particular Attorney General *Locus Standi* and representation for the Councils. This means that, because Attorney General is not supposed to appear for the Councils, they are not government entities. In *Kgarebe v Attorney General*,[28] an obstetrician and gynaecologist appealed against her removal from the register and instituted a claim against the Attorney-General as a representative of the Council. In all the proceedings, the Attorney-General was cited as the respondent, even though the action was not objected to. Wallia J observed that the *locus standi* of the parties is fundamental to due process, and without it, the proceedings would be invalidated; the judge also stated that *locus standi in judicio* is a matter of law, and it cannot be conferred by consent.

The court held that the Attorney-General is appointed under section 51 of the Constitution and in terms of section 51(3) as the principal legal adviser to the government; the council is not an organ of the government and its members are not necessarily public officers. The court held that the council is not higher than or in the same category as statutory bodies constituted in the relevant statutes to regulate the affairs of various professions, such as the Nurses' and Midwifery Council of Botswana, the Veterinary Surgeons' Council and the Engineers' Registration Board. The case was dismissed with costs, but it clarified that the councils are independent of the government.

Similarly, *Ramasu and Another v Nurses and Midwifery Council of Botswana and Ors*[29] concerned two nurses who were suspended from the register of nurses for alleged sub-standard obstetric care. As in *Kgarebe*, the Nurses' and Midwifery Council of Botswana was represented by the Attorney-General, and the case was lost on technicalities, without its merits being examined. The main issue was that the Attorney-General should not have represented a semi-autonomous body, such as the Nurses' and Midwifery Council. The arm's-length oversight in the government's financing of the health profession councils has thus given rise to issues of legal identity.

Case law in Botswana has also examined the need to observe the public interest in the functioning of the councils. In *Boalotswe v Botswana Health Professions Council and Another*,[30] the appellant questioned the Council's decision to decline his registration as a specialist maxillo-facial surgeon. Howie JA, in passing judgment, indicated that registration is important, especially because the government funds it, and the question about an aggrieved applicant not being registered is also paramount as registrants are expected to provide services:

27 Ibid.
28 *Kgarebe v Attorney General* (2012) BLR 730 (HC).
29 *Dyina Ontiretse Ramasu and Joshua Motlhobogwa v Nursing and Midwifery Council of Botswana and Others* Case Number MAHGB-000500-19 of 25 May 2020.
30 *Boalotswe v Health Professions Council and Another* (2018) 3 BLR 175 (CA).

> [I]t is also in the public interest that a registration applicant having the requisite qualifications and the potential to be of significant benefit to the public should not be thwarted by procedural irregularities that would ordinarily be remedied by way of judicial review.[31]

Hence, in the registration of health professionals and their de-registration, when their fitness to practise is in question, it is also vital to consider the inherent public interest that is derived by having professionals who are registered to practise and not denying the public access to these professionals.

In *Verma v Attorney General*,[32] the Court of Appeal heard a case in which foreign qualifications in optometry were questioned by the Botswana Health Professions Council, which led to the non-renewal of an optometrist's registration. The remedy that was sought was premised on section 94 of the Botswana Health Professions Act, which requires that the qualifications must allow the professional to be registered in the country where the qualification was obtained. The evidence from the qualifications body in India indicated that the diploma in ophthalmic assistance (which the appellant had) was actually the same as the qualification required in terms of Schedule B to the Act, Optometry. The court also held that section 9 of the Act does not authorise the council to remove a registrant from the roll on the grounds that he or she was erroneously registered, but a registrant could be removed on grounds that registration was obtained by fraudulent means. The council's reliance on section 9 was held to be *ultra vires* the Act and was set aside.

In *Bhagat v Botswana Health Professions Council and Another*,[33] the Court of Appeal was presented with an appeal by a doctor who was denied registration as a cardiologist. Section 9(4)(a) of the Botswana Health Professions Act was key in the case. The court held that on a proper interpretation of section 9(4)(a) of the Act, evidence of registration as a cardiologist in the UK was not a requirement for the appellant's registration as a cardiologist in Botswana. Evidence that his qualification entitled him to practise as a cardiologist in the UK was all that was required, and the evidence presented satisfied the court that this was the case. The appeal was upheld and the council's decision was quashed.

The same section of the law was crucial in *Boalotswe v Botswana Health Professions Council and Another*,[34] where an appeal was made by a dentist who was qualified as a Master of Clinical Stomatology. The appellant had approached the council for registration as an oral maxillo-facial surgeon and was turned down. The case was dismissed on the grounds that his qualification did not entitle him to practise in the country in which the said qualification was obtained (China); the evidence indicated that the appellant had to write and pass a licentiate examination over and above his qualification to be able to practise in China. The case is quite similar to the *Bhagat* case but it yielded a different result. Howie JA observed that the presentation of the case may be subject to different interpretations. The main difference was that, in the *Bhagat* matter, the appellant did not have to do an additional examination to be entitled to practise in the UK.

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31 Ibid.
32 *Verma v The Attorney General* (2009) 2 BLR 218 (CA).
33 *Bhagat v Botswana Health Professions Council and Another* (2018) 2 BLR 32 (CA).
34 *Boalotswe v Health Professions Council and Another* (2018) 3 BLR 175 (CA).

4. Comparing the registration of health professionals in Botswana and the UK

4.1 The Professional Standards Authority in the UK

In the UK, the Professional Standards Authority for Health and Social Care is a regulator of regulators established under section 25 of the National Health Service Reform and Health Care Professions Act 2002. The Authority oversees the statutory bodies that regulate health care professionals, reviews their performance, and assesses how they are protecting the public. In addition, the authority scrutinises the regulators' decisions about whether professionals on their registers are fit to practise and can appeal these decisions if it is of opinion that they fail to protect the public.[35] According to section 29(4) of the Act,

> Where a relevant decision is made, the Authority may refer the case to the relevant court if it considers that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.
>
> Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient–
>
> (a) to protect the health, safety and well-being of the public;
>
> (b) to maintain public confidence in the profession concerned; and
>
> (c) to maintain proper professional standards and conduct for members of that profession.[36]

The Authority polices the regulators and requests judicial reviews of the regulators' decisions. It also sets the standards with which the regulators must conform. The regulators have the over-arching responsibility of public safety and well-being. The laws of the UK thus provide a second layer of public safety protection.

In Botswana, the registration of health professionals is conducted by the Botswana Health Professions Council (BHPC) and the Nursing and Midwifery Council of Botswana (NMCB). The two councils have generally similar arrangements. The process involves an initial application and a payment to be entered onto the relevant register, and an appeal process if the registration is not successful. The BHPC and the NMCB keep registers of professionals according to the Schedules of professions.

According to section 9 of the Botswana Health Professions Act:

> (1) A person shall not practise as a medical practitioner, dentist, pharmacist or intern, or as a member of an allied health profession unless he is registered as such in the appropriate register in accordance with section 11, and has obtained a certificate of registration …
>
> (2) An application for registration in subsection (1) shall be made to the Council in writing, accompanied by–
>
> (a) the applicant's identity and such proof of the qualifications on which the applicant relies;

35 Professional Standards Authority (2020) 'Mandate of Professional Standards Authority' <www.professionalstandards.org.uk/h> accessed 12 December 2020.

36 National Health Service Reform and Health Care Professions Act 2002 [CAP 17].

(b) the applicant's certificate of good character and standing …;

(c) a sworn declaration of oath …; and

(d) any other information as the Council may require.

Similarly, regulation 3 of the Nurses and Midwives (Registration) Regulations, 2011[37] provides for applications for registration and the issuing of certificates of registration. Regulation 7 also provides for the annual renewal of practising certificates. Furthermore, the regulations allow the council to refuse applications to register, if the applicant fails to meet the requirements specified in the regulations, has been convicted of an offence, or is found to be unfit to practise by the council. Registration can also be suspended for unfitness to practise or unprofessional conduct. The council is also empowered to revoke the certificate of registration where a nurse or midwife is convicted of an offence, or if there is reason to believe that it is in the public interest to do so.

4.2 Aspects of the registration of health professionals in the UK and Botswana

There are very important commonalities in relation to the registration of health professionals in the UK and Botswana. The statutes define what qualifications are required for the registration of professionals. Provision is made for the recognition of qualifications from local institutions and further scrutiny and criteria are needed for the acceptance of qualifications from outside the two countries. The UK's Dentists Act, 1984 provides for a 'recognised overseas diploma' and the UK's Medical Act, 1983 provides for an 'acceptable overseas qualification'; these allow the councils to register professionals from other countries.

In the UK, the GMC also provides criteria for qualifying candidates from the EU and other countries, in terms of section 17. The same principles are seen in the Botswana laws. According to section 9(4) of the Botswana Health Professions Act:

> Qualifications from a university or other institution outside Botswana shall not be accepted as qualifications for registration unless–
>
> (a) the qualification entitles the holder thereof to practise the relevant profession in the country in which such university of institution is situated; and
>
> (b) the Council is satisfied that the possession of such qualification indicates a standard of professional education not lower than that required by the Council for practice of such a profession in Botswana.

Similarly, section 7(2) of the Botswana Nurses and Midwives Act gives the council the power 'to approve, subject to inspection, schools of nursing and institutions where student nurses and midwives, and enrolled nurses are trained'. Further, the Act obligates citizens qualifying in Botswana to register within 90 days of qualification.

In the UK, fitness to practise is a requirement in all the regulatory bodies' statutory instruments; however, it is not clearly agreed what fitness to practise is. According to the GMC's Fitness to Practise Guidance:

37 Nurses and Midwives Registration Regulations, 2011.

> A question of fitness to practise is likely to arise if:
>
> > a doctor's performance has harmed patients or put patients at risk of harm …
> >
> > a doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients …
> >
> > a doctor's health is compromising patient safety …
> >
> > a doctor has abused a patient's trust or violated a patient's autonomy or other fundamental rights …
> >
> > a doctor has behaved dishonestly, fraudulently or in a way designed to harm or mislead others …[38]

Other bodies, such as the Nurses and Midwives Council, limit fitness to practise to skills, knowledge, health and character attributes that allow nurse to perform their duties effectively. The Health Care Professions Council, the General Dental Council and the General Optical Council seem to define fitness to practise by these four attributes predominantly, making the GMC's definition the broadest. The Botswana Health Professions Act requires one to have a good character and standing in order to be registered with the Botswana Health Professions Council. Furthermore, the Botswana Nursing and Midwifery Council is authorised by regulation 9 of the Nursing and Midwifes Registration Regulations to remove a registrant who is unfit to practise from the register.[39] The characteristics of unfitness include physical and mental incapacity demonstrated by a medical practitioner. Other characteristics indicating a lack of fitness to practise (as highlighted by the UK laws), such as dishonest behaviour, are legislated for in the subsidiary legislation of the Botswana Health Professional Conduct Regulations.[40]

The requirement of a state of good health by the UK regulators is also subject to the Equality Act, 2010 as the Act prohibits discrimination. This includes curbing of regulators setting of registration criteria that are biased to a person's characteristics, such as disability. However, self-disclosures to the regulator about one's disability are necessary if there is a potential safety problem for the public. In *R (AR) v Chief Constable of Greater Manchester Police*,[41] police disclosure was seen as contravening the right to private life in Article 8 of the Human Rights Act, 1998. Regulators use disclosed information but do not use it as the main reason for not registering an applicant.[42] In addition, the police have a discretion whether to disclose or not, and they are guided by the Statutory Disclosure Guidance Act, 2015.[43] The disclosed information is used in tandem with other information to form an

38 General Medical Council 'The Meaning of Fitness to Practise' (2014) <https://www.gmc-uk.org/-/media/documents/dc4591-the-meaning-of-fitness-to-practise-25416562.pdf> accessed 11 December 2020.

39 Nurses and Midwives Registration Regulations, 2011, reg 9.

40 Botswana Health Profession Council Professional Conduct Regulations, 1988, reg 28.

41 *R (AR) v Chief Constable of Greater Manchester Police* (2018) UKSC 47.

42 Gomez, D *The Regulation of Healthcare Professionals: Law, Principle and Process* (Sweet & Maxwell 2019) 159.

43 England Home Office (2015) 'Statutory Disclosure Guidance' <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/452321/6_1155_HO_LW_Stat_Dis_Guide-v3.pdf> accessed 12 December 2020.

opinion. In the UK, the regulators provide for the requirements for registration, including good character, in guiding documents. The Department of Health has called for the litmus test of character to be a requirement.[44] Consequently, the Professional Standards Authority published documentation highlighting the common factors that regulators should use in assessing character.[45] The guide highlights four factors that bring the character of an applicant into doubt. It highlights that an applicant or registrant may have problems of character if he or she has been proven to, or has the potential to, behave:

> in such a way that puts at risk the health, safety or wellbeing of a patient or other member of the public;
>
> in such a way that his/her registration would undermine public confidence in the profession;
>
> in such a way that indicates an unwillingness to act in accordance with the standards of the profession;
>
> in a dishonest manner.[46]

Regulators assess character through a series of questions that are asked in applications. Requests are made for disclosures of criminal convictions, civil proceedings and sanctions that would otherwise not be allowed to be disclosed under the Rehabilitation of Offenders Act, 1974. The Professional Standards Authority guide also recommends that regulators should not only rely on certificates of good standing and character from an applicant's peers, but should have a clear framework for establishing good character. The same burden of establishing good health and character applies to applications made in terms of the Botswana Regulatory Council's processes.

UK case law has defined certain attributes relating to health profession registration and fitness to practise. Gomez observed that courts should look at the same standards of character when assessing applications for registration or meting out sanctions,[47] as held in *Council for Regulation Healthcare Professionals v General Dental Council and Fleishmann*.[48] However, as seen in *Mulla v Solicitors Regulation Authority*,[49] it was reiterated that striking off an established practitioner and declining registration because of a newly qualified entrant's character assessment are clearly focused on public safety as a priority. However, a court has observed that there ought to be a distinction between the two scenarios. *Doherty v Nursing and Midwifery Council*[50] involved a nurse who was involved in a drink-drive offence within her three-year registration retention cycle. The Nursing and Midwifery Council took her

44 Secretary of State for Health *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (Department of Health 2007).

45 Professional Standards Authority 'Common Approach to Good Character' (2008). <https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/common-approach-to-good-character-2008.pdf?sfvrsn=72c67f20> accessed 12 December 2020.

46 Ibid.

47 Gomez (note 44) 77.

48 *Council for the Regulation of Health Care Professionals v General Dental Council and Fleischmann* (2005) EWHC 87 (Admin).

49 *Mulla v Solicitors Regulation Authority* (2010) EWHC 3077 (Admin).

50 *Doherty v Nursing and Midwifery Council* (2017) EWCA Civ 1344.

conviction into account when considering the renewal of her registration application, as opposed to considering it as an independent fitness to practise issue. The council declined her renewal, saying that her behaviour was incompatible with being a safe nurse. The Court of Appeal held in favour of appellant and ruled that the regimes of registration/de-registration and fitness to practise are different; the one has a yes or no outcome, while the other has a continuum of remedies. The court held that striking a nurse off the register rather than imposing a sanction, such as suspension and rehabilitation, is not in the interests of justice, as striking off means the applicant would have to re-apply for registration, which has a defined waiting period. Suspension of permission to practice and rehabilitation of the registrant allow for more interrogation of the crime and an assessment of the character features involved. It may not have a waiting period after sanction has been served.

With regard to fitness to practise, in the UK, there are differences in the approaches to fitness to practise but, as Gomez observes, the common feature is the presence of a panel that decides whether fitness to practise is impaired.[51] Matters of fitness to practise often affect the registration of a practitioner. The names of the panels that assess and decide fitness to practise differ; some are referred to as fitness to practise committees and others are referred to as professional conduct committees. *Council for the Regulation of Healthcare Professionals v General Medical Council and Ruscillo,*[52] established that committees must assess matters in detail, their role must be inquisitorial and fact-finding, and their procedures or processes must be exhaustive.

The fitness to practise part of the laws in the UK and those in Botswana differ. In the UK, the fitness to practise processes of regulators differ.

4.3 Retention of professionals on registers

In both Botswana and the UK, registered professionals can renew their membership by paying a fee and fulfilling subsequent provisions to ensure that they are continually up-to-date with professional practice standards. All professional bodies in the UK enforce continuing professional development (CPD). In Botswana, the registration of health professionals under the Health Professions Act and the Nurses and Midwives Act is renewed annually and CPD points are awarded for ongoing training by development platforms for the two councils. In the UK, the GMC oversees revalidation exercise where the competencies of doctors are reassessed periodically to ensure that they have the required skill sets. Botswana does not have revalidation exercises to re-assess professionals for competency.

4.4 Professional misconduct and registration or de-registration

Professional misconduct is one aspect of regulation that affects fitness to practise. In fact, sanctions for professional misconduct are among the most serious, often leading to de-registration. There is no absolute definition of professional misconduct in the UK, with the principle being considered as a fitness to practise matter. With effect from 1 November 2004, the GMC's disciplinary procedures were reformed by the Medical Act

51 Gomez (note 44) 77.

52 *Council for the Regulation of Healthcare Professionals v General Medical Council and Ruscillo* (2004) EWHC 527 (Admin).

(Amendment) Order, 2002.[53] The concepts of 'serious professional misconduct', 'seriously deficient performance' and 'seriously impaired health' were replaced by a unified concept of impaired fitness to practise.[54] This approach is broadly seen in other professions.

It can be argued that the UK laws had an ambiguous term for professional misconduct and replaced it with another broad term, fitness to practise. The legal definition of misconduct was proffered in *Howd v Bar Standards Board*.[55] The court found that, on a literal interpretation, any breach of a professional code, however trivial, would constitute professional misconduct. However, the court held that this could not be the correct approach:

> [C]onsistently authorities have made clear that the stigma and sanctions attached to the concept of professional misconduct across the professions generally are not to be applied for trivial lapses and, on the contrary, only arise if the misconduct is properly regarded as serious … the concept of professional misconduct carries resounding overtones of seriousness, reprehensible conduct which cannot extend to the trivial.[56]

The Botswana Code of Professional and Ethical Conduct for Nurses and Midwives defines misconduct as 'unacceptable or irresponsible behaviour especially by a professional'.[57] The Botswana Health Professions Act also provides for disciplinary proceedings against a professional who has committed 'improper or disgraceful conduct of a professional nature'.[58] Removal from the register is one of the sanctions, based on the seriousness of the misconduct, that the two councils can impose.

In the UK, the leading cases on professional misconduct sanctions in relation to health profession registration are *Meadow*[59] and *Bawa-Garba*,[60] both of which involved the GMC. In *Meadow* a renowned professional, Sir Meadow, had given evidence in a case where Ms Clark was charged in relation to the deaths of her children (*R v Clark*). The paediatrician gave evidence that had a huge impact on the case, leading to the conviction and incarceration of Ms Clark. It later emerged that Sir Meadow's evidence was wrongly presented, and that he had provided statistical conclusions that were not within his ambit. Fresh evidence presented later showed that Ms Clark was innocent.

In *Bawa-Garba*, a doctor was convicted of gross negligence manslaughter after the death of a baby under her care. The court concluded that she failed to act prudently, her level of care was judged to be exceptionally poor, and she was convicted of manslaughter.

In both cases, the doctors then appeared before the Medical Practitioners' Tribunal Services (MPTS) and were charged with serious professional misconduct, with the sanction of removal from the register. Bawa-Garba was later restored to the register after

53 Medical Act (Amendment) Order 2002 (SI 2002/3135).
54 *General Medical Council v Meadow* (2006) EWCA Civ 1390.
55 *Howd v Bar Standards Board* (2017) EWHC 210.
56 Ibid para 51, per Lang J.
57 Nurses and Midwives (Professional Ethics and Practice) Regulations, 2014.
58 Botswana Health Professions Act, 2001, s 14(1).
59 *General Medical Council v Meadow* (2006) EWCA Civ 1390.
60 *General Medical Council v Bawa-Garba* (2018) EWHC 76 (Admin).

an appeal. Several commentaries on the case have presented varying opinions. One paper observed the challenges of transparency, public confidence, and concerns that, without the benefit of research, neither the courts nor the professional tribunal can credibly claim to have expertise in what the public thinks.[61] Another paper observed inconsistencies in decisions about gross negligence manslaughter; the author compared three cases in the UK and opined that a code must be implemented to assess such cases.[62]

In *Meadow*, the court held, giving expert evidence does not make doctors immune to prosecution and sanction by a regulatory body. However, in view of the gross professional misconduct, the court held that a misinterpretation of clinical facts does not warrant removal from the register.

In *Bawa-Garba* the council appealed the MPTS's decision to remove the doctor from the register to the Court of Appeal. The court held that the MPTS should re-evaluate Dr Bawa-Garba andconsider *Bijl v General Medical Council*,[63] where it was held that the competency of a professional does matter significantly when considering their permanent removal from the register. It was clear that Dr Bawa-Garba was a competent doctor who presented no material danger to the public, and her future service to society was in the public interest.

The decisions of disciplinary committees in relation to removal from the registers of regulatory bodies can be appealed to the Privy Council, as provided for by section 29 of the Dentists Act, 1984, for example. In *Preiss v General Dental Council*,[64] on acquittal of a dentist from sanction of de-registration for gross negligence, is was held that serious professional misconduct does not require moral improbity; something more is required than a degree of negligence, enough to give rise to civil liability, but not calling for the contempt that inevitably attaches to the disciplinary process. In *Ghosh v General Medical Council*,[65] the court emphasised that the powers of the Privy Council may not be limited as previously presented. Therefore, while it was observed from *Libman v General Medical Council*[66] the findings of a professional disciplinary committee should not be altered unless they are disturbingly out of line with the evidence to indicate with reasonable certainty that the evidence was misread. Therefore, the Privy Council can direct the regulatory bodies in the line of censure, and as Ghosh determined, the case and deviation will be the main guidance.

5. Public interest

Public interest is not limited to regulating health professionals. It is seen across all public administration processes, such as controlling fuel and electricity prices. Such control aims

61 Case, P & Sharma, G 'Promoting Public Confidence in the Medical Profession: Learning from the Case of Dr. Bawa-Garba' (2020) *Medical Law International* 71.

62 Amara, FD 'The Cases of Rose (Honey Maria) [2017] EWCA Crim 1168, Bawa-Garba (Hadiza) [2016] EWCA Crim 1841, and JM and SM [2012] EWCA Crim 2293: A Critical Analysis of the Disordered State of the Law of Involuntary Manslaughter' <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4920229> accessed 15 February 2024.

63 *Bijl v General Medical Council* (2001) UKPC 42.

64 *Preiss v General Dental Council* (2001) UKPC 36.

65 *Ghosh v General Medical Council* (1982) UKPC 38.

66 *Libman v General Medical Council* (1972) AC 217.

to ensure prices do not increase so much that the public cannot afford fuel and electricity. Regulation or rule-making is a key policy and a legal initiative that assists in demarcating political and economic roles.[67] The public interest must be maintained at all costs.

The regulations emphasise the public safety aspect; regulation 3(d) of Botswana's Nurses and Midwives Disciplinary Regulations, 2011 provides that anyone who

> during the course of his or her practice as a nurse, enrolled nurse or midwife
>
> (i) acts carelessly,
>
> (ii) acts incompetently,
>
> (iii) acts improperly,
>
> (iv) assaults or batters a patient, client or colleague,
>
> (v) provides services that are not appropriate for the patient's wellbeing…
>
> commits an offence.

The regulations further prohibit a nurse from acting outside his or her scope. This approach protects the public by heeding the over-arching objective of ensuring public safety.

According to the *Webster Legal Dictionary*,[68] the term 'public interest' means a notion depicting that 'the general welfare and rights of the public are to be recognized, protected, and advanced'. The public interest value proposition provided by self-regulating health professions has been questioned, with Canada given as an example. One article argues that there is a trade-off between self-regulating professionals' interests, the state agenda and the public interest in general.[69] In addition to regulating a market, public interest is tied to human rights and there is an increasingly business-focused definition of the public interest that is coupled with patients' rights. In recent decades there has been a significant shift in public interest narratives, with an emphasis on limiting harm to the consumers of professional services, rather than benefiting the public, more broadly, as defined in the dictionary entry.

It is clear that the public interest is echoed in all the laws of health profession regulation in the UK and Botswana. Section 38 of the UK's Medical Act, as quoted in *Krippendorf v The General Medical Council*,[70] provides that 'on giving a direction for suspension under section 36A in respect of any person, the Committee on Professional Performance "*if satisfied that to do so is necessary for the protection of members of the public or would be in the best interests of that person, may order that his registration in the register shall be suspended forthwith*"'.

67 Levi-Faur, D, Kariv-Teitelbaum, Y & Medzini, R 'Regulatory Governance: History, Theories, Strategies, and Challenges' (2021) *Oxford Research Encyclopedia of Politics* <https://oxfordre.com/politics/view/10.1093/acrefore/9780190228637.001.0001/acrefore-9780190228637-e-1430>9 accessed 12 May 2024.

68 Merriam Webster Online Dictionary, available at <https://www.merriamwebster.com/dictionary/interest#legalDictionary> accessed 12 May 2024.

69 Adams, TL 'Professional Self-Regulation and the Public Interest in Canada' (2016) 6(3) *Professions and Professionalism* 1587.

70 *Krippendorf v The General Medical Council (General Medical Council)* [2000] UKPC 45.

A similar rendition of the provisions appears in section 14(3) of Botswana's Health Professions Act:

> The Council may order
>
> (a) the suspension from practice of any practitioner in respect of whom an enquiry is pending or being held, or against whom criminal proceedings are pending or being brought, pending the final outcome of the enquiry or proceedings; or
>
> (b) that the continued practice of any practitioner pending the outcome of any enquiry shall, in the interests of the public or the practitioner, be subject to such conditions and requirements as the Council considers necessary or desirable.

Public interest is prioritised to an effect that the registration of a practitioner can be given with conditions.

In South Africa and Namibia, similar laws can be noted. Section 2(1) of South Africa's Health Professions Act 56 of 1974 states that some of the objectives of the Council are:

> to serve and protect the public in matters involving the rendering of health services by persons practising a health profession; and
>
> to exercise its powers and discharge its responsibilities in the best interests of the public and in accordance with national health policy determined by the minister; and
>
> to be transparent and accountable to the public in achieving its objectives and when performing its functions and when exercising its powers.

Similarly, in Namibia, section 5(b) of the Medical and Dental Act 10 of 2004 states that one of the objects of the Act is:

> to communicate to the Minister information on matters of public interest acquired by it in the course of the performance of its functions in terms of the Act.

In the South African statute, public interest is taken a notch higher. The Health Professions Act 56 of 1974 emphasizes the council's duty to act in the public interest and to be transparent to both the profession and the general public in achieving its objectives. Such a mandate of responsibility to the public and transparency shows the importance of the public as a key stakeholder in the laws concerning the registration of professionals.

6. Conclusion

The principles of health profession registration in Botswana and the UK aim to protect the public interest. Fitness to practise, professional conduct, the evaluation of competencies and qualifications are important to ensure that the public receives safe care. The governance structures of the councils differ in the two countries: the Botswana statute gives the Minister of Health oversight of the councils, while in the UK, the Professional Standards Authority has the authority to evaluate decisions of the councils and even appeal them in court. Botswana could consider introducing an oversight authority to evaluate the

regulators' decisions. It accords an independent adjudication with a possibility of judicial action taken up by the authority, without involving the aggrieved party, being a registrant or a member of the public.

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