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Regulation of the medical profession in Sri Lanka: reform is urgently needed

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Medical practitioners in Sri Lanka are granted the power to regulate their profession by the Medical Ordinance (Chapter 105) [1]. Self-regulation is a 'contract' between the public and the profession; a concept which grew out of the need to protect the public from quacks, in the latter half of the 19th century in the UK [2]. The medical profession is given this autonomy on the assumption that it will provide the public with good doctors and protect it from unqualified practitioners. Many doctors believe that self-regulation is a right which should be jealously guarded, but in fact, it is only a privilege that is conditional on the profession keeping its part of the bargain [3]. Failure on the part of the profession to live up to public expectations can result in radical changes, as has happened in the UK and India.

In the UK in the 1990s, there was a widespread perception that the General Medical Council (GMC) had failed as a regulator in protecting the public from poor practice [3]. However, by conducting an efficient and complex investigation into failures in paediatric cardiac surgery in Bristol (which resulted in two surgeons and the medically qualified chief executive of the hospital being found guilty of serious professional misconduct in 1998), the GMC was seen to have vindicated itself. Following this enquiry, the GMC decided that all doctors in active practice should have their practice evaluated regularly, to demonstrate that they are up-to-date and fit to practise. Registration is now linked to revalidation [3].

More recently, the Parliament of India decided that the Medical Council of India (MCI) had repeatedly failed to fulfil its responsibilities. A report placed before Parliament in 2016 underscored allegations of corruption, principally in relation to governance of medical education [4]. Deficiencies in regulation of the professional conduct of doctors, and in maintenance of the Indian Medical Register were also highlighted. Concluding that the MCI could no longer be entrusted with responsibility for reform, the report recommended formation of a National Medical Commission through a new Act. In 2018 the MCI was dissolved by presidential order and replaced by an interim Board of Governors [5], but the National Medical Commission Bill is still pending.

The Medical Ordinance became effective in 1928, during our colonial era, probably mirroring regulations governing the UK's GMC. It established the Ceylon Medical College Council (CMCC) and the Ceylon Medical Council, the precursor of the Sri Lanka Medical Council (SLMC). The CMCC is mandated with oversight of standards of education of allied health



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professionals and with issuance of certificates of efficiency or proficiency prior to registration by the SLMC. The more recently established Sri Lanka Nurses Council regulates nursing education, registration of nurses, and their professional conduct. The SLMC is empowered to register medical and dental practitioners and all health professionals other than nurses; to ensure standards of education for medical and dental practitioners and their postgraduate education; and to enquire into complaints of professional misconduct [1].

Although our Medical Ordinance has been amended many times since its enactment over 90 years ago, it still has major shortcomings and deficiencies when judged by our current understanding of professional ethics and what is expected of a regulatory body. The need to protect professions named in the Ordinance from unqualified practitioners appears to be the main purpose of the Ordinance, reflecting the social context when it was first enacted. In contrast, the primary objectives of the GMC, as set out in the Medical Act of 1983 are to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the medical profession; and to promote and maintain proper professional standards and conduct for members of that profession [6]. The idea that the primary function of the SLMC should be protection and promotion of the health and well-being of the public of Sri Lanka is completely missing.

Membership of the GMC has evolved from an initial 24 in 1858, through to 104 members mostly elected by the profession, to the present 12-member composition with six lay and six registrant members [7]. The Indian Parliamentary Report of 2016 noted that the MCI had 104 members, 36 of whom were nominated and 68 were elected. The Committee was of the view that its composition was biased against the larger public health goals and public interest and recommended that it should be brought down to 20 nominated members [4].

The current membership of the SLMC is confined to medical practitioners and dental practitioners, and does not include representation of other professions or lay persons. The membership of the CMCC consists of academic staff members of the Faculty of Medicine, University of Colombo, with minimal representation of the allied health professions [1]. Major groups of stakeholders are thus excluded from both bodies. Moreover, there is no provision in the Ordinance or relevant regulations, to ensure that persons whose professional and personal responsibilities and commitments may come into conflict with the mandate of the regulatory body, do not become Council members.

The Medical Ordinance provides for provisional registration of medical and dental practitioners (during internship); full registration, which has to be renewed every five years and is open to Sri Lankan citizens only;

temporary registration for non-Sri Lankan citizens; and specialist registration, brought in under the most recent amendment. The clauses pertaining to provisional and full registration have been subject to repeated amendment and are now extremely convoluted. Moreover, renewal of registration does not require any evidence of continued fitness to practice. Although the need to link registration to revalidation has been discussed in the past, the necessary amendments have not been enacted.

The list of allied health professions registered by the Council is out-dated and insufficient. For example, it makes no distinction between audiologists (who are graduates) and audiometricians (who are not). The categorization into para-medical assistants and professions supplementary to medicine appears to be quite arbitrary. There are major inconsistencies in the processes to be followed in the registration of different categories of professionals. In addition, provision for granting temporary registration to allied health professionals who are not Sri Lankan citizens requires authorization from the Head of State, resulting in major difficulties and delays.

The World Health Organization recommends accreditation of medical schools by independent agencies as essential for ensuring the quality of medical education [8]. The WFME has a procedure whereby it recognizes agencies that accredit medical schools [9]. A medical school that is accredited in this manner can justifiably claim that it meets international standards. However, the term 'accreditation' does not appear in the Ordinance, probably because it is a concept of recent origin.

The 11 medical schools in Sri Lanka function under the Ministry of Higher Education and the Ministry of Defence, while the legal mandate for maintenance of educational standards lies with the SLMC, which is under the Ministry of Health. For the SLMC to accredit medical schools in Sri Lanka and become eligible to seek WFME recognition, it must have legally valid standards for medical education. However, repeated efforts by the SLMC to develop such standards have been unsuccessful, because the Medical Ordinance requires that such regulations must be approved by Parliament.

Hundreds of Sri Lankans also go overseas each year for medical education and return after graduation, expecting to enter the profession. The SLMC requires inspection and recognition of foreign medical schools, before permitting their graduates to sit for its licensing examination, because some schools have been established for commercial rather than academic purposes. The GMC had a similar practice in the past, but stopped some years ago, owing to difficulties in implementation and now relies solely on a stringent licensing examination [10]. In our context, because so many Sri Lankans seek medical education overseas, a means of identifying schools that meet educational standards remains essential. However, if the SLMC is to replace 'recognition' of foreign medical

schools with a requirement of accreditation by a WFME-accredited agency, logically it must be in a position to also accredit any medical school in Sri Lanka.

At present, disciplinary enquiries are conducted by Council members who hear the complaint, determine if there has been professional misconduct and also decide on the punishment. This means that all decisions regarding professional misconduct are made by medical and dental practitioners, who act as prosecutor, jury and judge. Conflict of interest is almost inevitable, since the 'accused' are doctors, and the 'jury and judge' are also doctors who may be subject to bias.

The two-tiered process of hearings by a 5-member Preliminary Proceedings Committee followed by the 10-member Professional Conduct Committee is cumbersome and unwieldy, resulting in long delays in reaching a final determination in cases of serious professional misconduct. This does not serve the best interests of the public, nor of the accused medical practitioner.

Sri Lanka's Medical Ordinance is over 90 years old. It is now seriously outdated, resulting in grave deficiencies in regulation of the medical profession and allied health professions in Sri Lanka. We must make a strong push for new legislation which addresses these deficiencies now, before it is forced upon us.

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