JOINT SELECT COMMITTEE ON

LOCAL AUTHORITIES, SERVICE COMMISSIONS AND STATUTORY AUTHORITIES *(INCLUDING THE THA)*

4th Report

on an

Inquiry into the Regulation and Licensing of Medical Doctors by the Medical Board of Trinidad and Tobago

Second Session (2016/2017), 11th Parliament

Fourth Report

Of the

Joint Select Committee on Local Authorities, Service Commissions and Statutory Authorities (including the THA)

on an

Inquiry into the Regulation and Licensing of Medical Doctors by the Medical Board

Second Session (2016/2017), Eleventh Parliament

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ACRONYMS AND ABBREVIATIONS

ABBREVIATION	ORGANISATION
ACTT	Accreditation Council of Trinidad and Tobago
CAMC	Caribbean Association of Medical Councils
CME	Continuous Medical Education
CMO	Chief Medical Officer
DPP	Director of Public Prosecutions
GMC	General Medical Council
MBTT	Medical Board of Trinidad and Tobago
MOE	Ministry of Education
MOH	Ministry of Health
MoNS	Ministry of National Security
NIPDEC	National Insurance Property Development Company Limited
PAHO	Pan American Health Organisation
RHA	Regional Health Authority
SFGH	San Fernando General Hospital
SFTH	San Fernando Teaching Hospital
SWRHA	South-West Regional Health Authority
T&TMA	Trinidad and Tobago Medical Association
UK	United Kingdom
UTT	University of Trinidad and Tobago
UWI	University of the West Indies
WMA	World Medical Association

CONTENTS

LIST OF TABLES

LIST OF FIGURES AND CHARTS

LIST OF APPENDICES

EXECUTIVE SUMMARY

1.1 At its eighth meeting held on Wednesday 22nd June, 2016, the Committee resolved to inquire into the Operations of the Medical Board of Trinidad and Tobago (MBTT) in relation to the licensing and regulation of Medical Doctors and agreed that the following four (4) objectives would guide the inquiry:

i. **To understand the systems and procedures employed by the Medical Board and it Council to execute its mandate;**
ii. **To assess the practices and procedures adhered to by the Medical Council in relation to disciplinary proceedings involving medical doctors;**
iii. **To assess the criteria, standards and procedures in place for hiring and monitoring the performance of foreign Doctors;**
iv. **To assess the systems in place to protect patients against malpractice by Doctors.**

1.2. To this end, the Committee agreed to meet in public with officials of the MBTT and the Ministry of Health (MoH) on Friday 11th November, 2016 to discuss matters pertaining to the objectives of the inquiry.

1.3. The Committee obtained both oral and written evidence based on the objectives listed above. Some of the issues which were highlighted during the course of the inquiry included:

1. ***The Failure of the MBTT to implement a Medical Specialist Register;***
    a. The PS, MoH advised that although the Medical Board Act provides for the establishment of a Specialist Register, there has been some difficulty in finalizing the criteria for establishing the Register.
    b. The President of the Council further validated the claim that medical practitioners in Trinidad and Tobago do advertise as specialists.

2. ***Doctors Practicing Medicine without Renewing their Licenses***

   a. The President of the Council advised that the Act stipulates the procedure for registering as a medical practitioner but does not address the issue of license renewal. As such, there is no procedure to remove a doctor's name from the list of registered doctors for failing to pay the requisite annual fees.

3. ***Unregistered doctors***

   a. The MBTT was unable to confirm the number of unregistered foreign doctors in Trinidad and Tobago.

   b. The MB Act currently does not address the issue of unregistered doctors.

4. ***The Failure of the MBTT to implement a Malpractice Register***

   It was noted that an amendment to the Act was required for a malpractice register to be established.

5. ***Continuous Medical Education (CME)***

   It was highlighted that at present, continuous medical education was a voluntary exercise.

6. ***Training available to Doctors in Specialized Areas of Medicine***

   It was noted that there were a number local doctors in the health sector but very few specialists. It was indicated that there is a shortage of doctors holding qualifications in subspecialties in critical fields of medicine, for example; cardiology and gastroenterology.

7. ***The Lack of Opportunities for Young Doctors to Access Specialized Training***

   It was indicated that the high cost of training oversees, as well as the lack of local training programmes offered by the University of the West Indies (UWI) are factors hindering young doctors and Registrars from accessing specialized training.

8. ***The shortage of Forensic Pathologists***

   The acute shortage of Forensic Pathologist in the country is concerning as it impacts on the country's ability to fight Crime.

From observations made during this inquiry, the Committee has proffered recommendations which we believe will appropriately address the issues highlighted. A summary of these recommendations follow this Executive Summary.

We anticipate that the Parliament, MoH, RHA's, Medical Board and other stakeholders would give due consideration to the findings and recommendations contained in this Report with a view to enhancing the systems of regulating the practice of medicine in Trinidad and Tobago. The Committee looks forward to reviewing the Minster's response to this Report, which becomes due, sixty (60) days after it is presented to the Houses of Parliament.

SUMMARY OF RECOMMENDATIONS

The following is a consolidated list of recommendations proposed by the Committee:

The Committee recommended that the following be implemented in the short-term (3-6 months):

i. the immediate implementation of the Specialist Register outlining the respective doctor's qualification which should also be published on the websites of the MBTT and MoH;

ii. the list of registered doctors (full, temporary or provisional) be made accessible to the public via the website of the Medical Board and the Ministry of Health;

iii. due consideration be given to the costs and benefits of adopting the British model that focuses on a license retention fee as opposed to a license application fee.

iv. that the MBTT consider publishing a list of doctors who have failed to pay their annual fees.

v. that the Parliament be provided with an update on the policy guidelines for the implementation of the *Medical Board (Specialist Registration) Regulations 2014* within 60 days of the presentation of the report.

vi. that the Ministry of Health present to the Parliament a policy position on the regulation of allied health professionals (not inclusive on nurses) in Trinidad and Tobago within three months of the presentation of this report.

vii. that the policy position also be included in the establishment and maintenance of a register of qualified allopathic doctors as is done by the General Medical Council, UK.

viii. that information on conduct/actions that may amount to a malpractice by a medical doctor also be widely published (via the relevant websites).

ix. that the MoH utilise its partnership with foreign institutions to provide training for doctors locally to assist in fulfilling the requirements for CME.

x. that the MBTT collaborate with the MoH to establish a mechanism for monitoring and evaluating foreign doctors who are engaged in private practice.

The Committee recommended that the following be implemented in the medium term (7-12 months):

xi. that regulations be made to:

i. provide for an annual fee to be paid by members of the MBTT; and

ii. prescribe penalties for failure to pay such fees.

xii. that mandatory registration with the Board be regularised and medical doctors be held accountable for practicing without a valid registration with the MBTT and that sanctions or penalties be provided for in the "Act".

xiii. that a Board member against whom an allegation is made be mandated to respond to the allegations within the stipulated timeframe and that a doctor be given the option of seeking an extension of time to provide feedback on the complaint. Also, the establishment of a commensurate penalty for failure to provide a written response to allegations.

xiv. that the Specialist Register include a fee structure that must be adhered to by the specialists.

xv. the thorough review of the Medical Board Act by the Ministry of Health and MBTT in order to:

i. Provide greater autonomy to the Medical Council in the area of decision making.
ii. Reduce the lag time between approvals for decisions to be made.

xvi. that Section 6 of the Act be amended to stipulate that meetings of the Council be convene based on a quorum of members and that each council be given the authority to determine an appropriate quorum for conducting the council's meetings/proceedings.

xvii. that an investigative arm of the Board should be commissioned in conjunction with the Director of Public Prosecutor's (DPP) office.

xviii. that the Ministry of Health pursue stakeholder consultations regarding the appropriate modalities for a robust and effective system for conducting investigation into complaints made against medical practitioners.

xix. that the MBTT in collaboration with the MoH implement a strategy to ensure that all non-nationals are registered with the MBTT.

xx. that the Medical Council include in its draft legislation, the provisions for the creation of a malpractice register. The proposed amendment to the MB Act must also prescribe that this list shall be published along with a Register of doctors in good standing. This along with other amendments to the Act be submitted for the consideration/concurrence of the Minister of Health by the end of fiscal 2016/2017.

xxi. that all doctors be required to provide the MBTT with documentary evidence of CME activity biennially in order to maintain .

xxii. that amendments to Section 20 of the MB Act be submitted for the consideration/concurrence of the Minister of Health by the end of fiscal 2016/2017 with other amendments recommended by the MBTT.

xxiii. that the MBTT:

a. set out the framework of principles and behaviours that should guide CME activities in the form of a handbook for all doctors similar to that of the GMC's Continuing Professional Development Guidance for all doctors; and

b. raise awareness about trends, issues or opportunities that may be relevant to CME for the guidance of doctors via an annual bulletin that should be published on both the MBTT's and MoH's websites.

xxix. that consideration be given to the implementation of an automated time record management system for doctors employed in the Public Health System.

INTRODUCTION

Background[2]

Medical Board of Trinidad and Tobago (MBTT)

2.1. The MBTT was established pursuant to the Medical Board Act Chapter 29:50 ("the Act") and comprises all persons duly allowed to register as a Medical Practitioner in Trinidad and Tobago. The main function of the MBTT is to facilitate the registration of medical practitioners, certification of specialists and regulation of the profession.

The Council of the MBTT

2.2. Section 6 of the Act provides that there shall be a Council of the Board which shall be appointed by the Minister and shall consist of:

a) the Chief Medical Officer (CMO);
b) two medical practitioners;
c) four medical practitioners elected by the Board;
d) one person nominated by the Inter-Religious Organization;
e) an Attorney-at-law with at least five years' experience nominated by the Law Association of Trinidad and Tobago;
f) an accountant with at least five years' experience nominated by the Association of Chartered Accountants; and
g) a medical practitioner nominated by the UWI.

Functions of the Council of the MBTT[3]

2.3. The Act prescribes that the Council is responsible for *inter alia*:

i. making Rules and Regulations;
ii. validating medical certificate;
iii. enforcing penalties;

[2] http://mbtt.org/index.htm
[3] http://rgd.legalaffairs.gov.tt/laws2/alphabetical_list/lawspdfs/29.50.pdf

iv. sanctioning the prosecution of a medical doctor in accordance with the Act;
v. Maintaining a Register of Medical Practitioners in Trinidad and Tobago;
vi. Maintaining a "Register of Medical Specialist";
vii. Issuing of temporary licenses to practice medicine (Section 13);
viii. The annual Gazetting of the names of all Medical Practitioners and Medical Specialists registered;
ix. enforcement of discipline in the accordance with Section 24 of the Act.

2.4. Information on the Current Members serving on the Council are at Appendix III.

2.5. In accordance with Section 12 of the Act, the following persons may register once the Council is satisfied that he holds a diploma –
"(a) in respect of which he is entered or entitled to be entered on the Medical Register of the General Medical Council (GMC); and
(b) granted by an institution listed in the Schedule3,
He is of good character and a fit and proper person to practice medicine,…"

2.6. Section 13 of the Act addresses the provision of Temporary Licences. Disciplinary action may be taken against a person if it is proven that his conduct was "infamous or disgraceful". The following sanctions may be effected:
i. Censure or reprimand the medical practitioner;
ii. Suspend the medical practitioner for no more than two years; or
iii. Erase the name of the medical practitioner or specialist from the Register: or
iv. Revoke his Temporary License.

Objectives of the Inquiry

2.7. The Committee agreed that the objectives of the inquiry will be as follows:
i. To understand the systems and procedures employed by the Medical Board and it Council to execute its mandate;

ii. To assess the practices and procedures adhered to by the Medical Council in relation to disciplinary proceedings involving medical doctors;

iii. To assess the criteria, standards and procedures in place for hiring and monitoring the performance of foreign Doctors; and

iv. To assess the systems in place to protect patients against malpractice by Doctors.

Conduct of the Inquiry

2.8. A public hearing was held with representatives of MBTT, NIPDEC and the MoH on Friday November 11, 2016 at which time the Committee interviewed the officials on issues relevant to the inquiry objectives. Prior to the public hearing, the Committee wrote to the MBTT and the MoH requesting written responses to certain preliminary questions. The written responses submitted provided a frame of reference for the questions pursued at the hearing.

2.9. The MBTT was represented by:

i. Professor Terrence Anand Seemungal- President, MBTT

2.10. The MoH was represented by:

i. Mr. Richard Madray - Permanent Secretary, MoH
ii. Ms. Dianne Dhanpath - Deputy Permanent Secretary, MoH
iii. Dr. Akenath Misir - Chief Medical Officer, MoH
iv. Mr. Asif Ali, Health - Sector Advisor, MoH

2.11. The Committee also wrote to a defined sample of stakeholders to solicit their input on the topic.

2.12. The Minutes and Verbatim Notes are attached as Appendix I and Appendix II respectively.

Summary of Evidence together with Findings and Recommendations

Objective 1: To understand the systems and procedures employed by the Medical Board and it Council to execute its mandate.

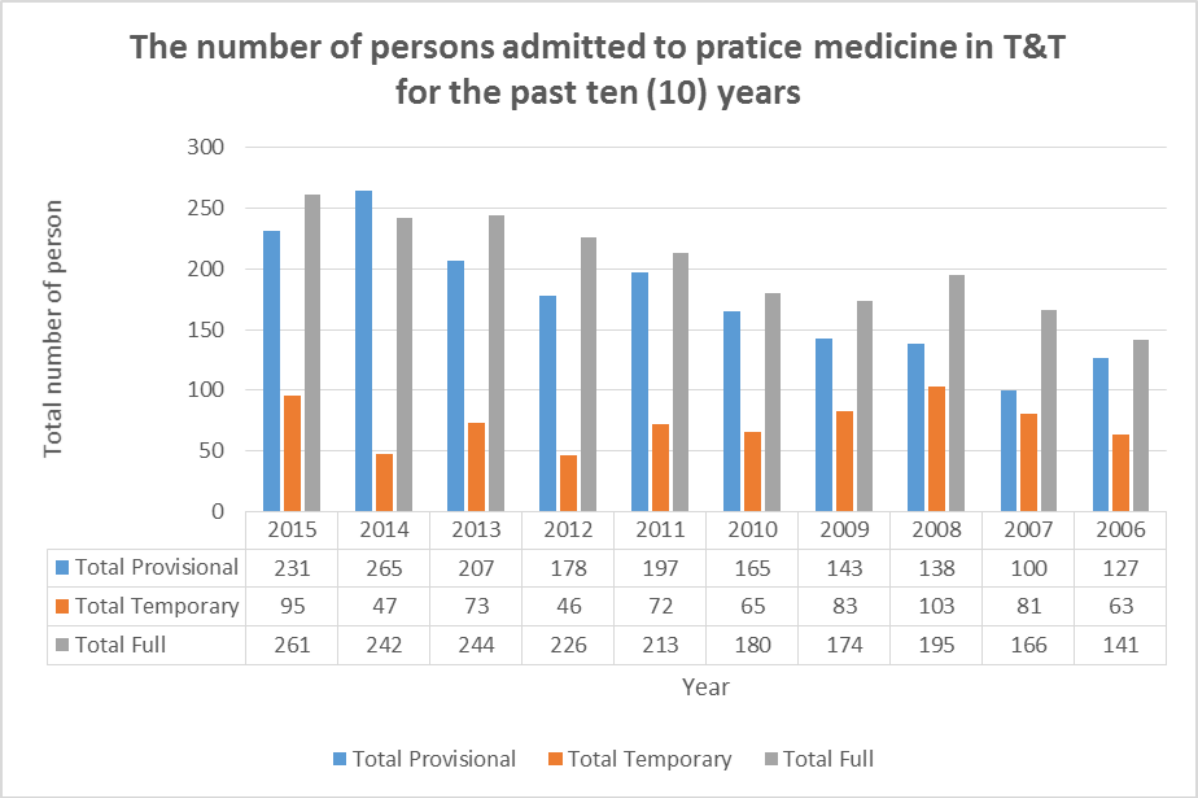
Medical Doctors Registered with the MBTT

3.1.1 The Committee attempted to determine the number of medical doctors that are registered with the MBTT and was advised that as at October 2016:

- 5,021 possessed Full Registration (unrestricted registration); and
- 334 persons possessed Provisional Registration (to pursue an internship in Trinidad and Tobago);
- 240 possessed Temporary Registration (to work in an approved public health institution).

3.1.2 The number of persons admitted to practice medicine in Trinidad and Tobago on an annual basis for the past ten (10) years is illustrated in Chart 1:

Chart 1:



	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
Total Provisional	231	265	207	178	197	165	143	138	100	127
Total Temporary	95	47	73	46	72	65	83	103	81	63
Total Full	261	242	244	226	213	180	174	195	166	141

Source: Medical Board of Trinidad and Tobago

Procedure for Registering with the MBTT

3.1.3 Registering with the MBTT involves a rigorous procedure which includes the submission of a certificate of good character and a doctor's certificate being validated by the MBTT to verify its authenticity. In cases where the applicant's

medical school is unknown to the MBTT, the respective doctor is requested to provide proof of accreditation or the MBTT will request assistance from the Accreditation Council of Trinidad and Tobago (ACTT) to determine whether the school is accredited. Additionally, in accordance with the Schedule of the Medical Board Act Chapter 29:50 the school must be listed in the World Directory of Medical Schools. If not listed or accredited, the doctor cannot be accredited. These protocols and procedures also apply to both full and temporary registration.

Best practices and benchmarks observed by the MBTT

3.1.4 The practices in the United Kingdom (UK) guides the operations of MBTT, as well as the execution of the Council's mandate in conjunction with the provisions outlined in the Medical Board Act.

Doctors practicing without renewing licenses

3.1.5 The Committee was informed by the MBTT that several doctors continue to practice without paying the annual fee stipulated by Section 14 (2). The Act does not provide for a procedure for license renewals. In this regard, the President of the Council made reference to the practice of the General Medical Council (GMC) of the UK which does not provide for a registration fee but an annual retention fee. Therefore, in cases where the retention fee is not paid, the doctors' name can be removed within a period of time from the register.

Temporary licenses

3.1.6 Over the past five (5) years, MBTT issued approximately 333 Temporary Licenses as illustrated in Table 1.

Table 1:
The number of Temporary Licenses issued over the last five (5) years

YEAR	TOTAL NUMBER
2015	95
2014	47
2013	73
2012	46
2011	72
Total	**333**

Source: Medical Board of Trinidad and Tobago

Medical Specialist Register

3.1.7 Section 10A of the Medical Board Act Chapter 29:50 stipulates that the Council should maintain a Medical Specialist Register. However, the MBTT admitted that the Register had not yet been implemented. The MoH indicated that there has been some difficulty in finalizing the criteria for entering the names of person on the Register of Specialists. Greater action was dedicated to this matter further to the making of the Medical Board (Specialist Registration) Regulations, 2014. At the time of the hearing, the Council was holding discussions with the MoH on this matter.

3.1.8 Notwithstanding the absence of a Specialist Register, there are medical practitioners in the country who advertise themselves as specialists and provide services to clients. The Committee was advised that some doctors who practice locally are registered/qualified as specialists in other jurisdictions such as the UK and North America. Furthermore, it was indicated that a doctor can conduct the

duties of a specialist practitioner but cannot advertise or misrepresent himself as such unless he is officially recognized as a specialist. Another issue highlighted was that there are doctors who have practiced in other jurisdictions as specialists but encounter barriers when they seek to practice in Trinidad and Tobago.

3.1.9 Table 2 outlines the number of doctors in each area of specialty that have attained specialist qualifications as at October 2016.

Table 2:

Doctors in each area of specialty that are deem specialist.

AREA OF SPECIALTY	TOTAL NUMBER
Accident & Emergency	18
Anesthesiology	89
Forensic Pathology	2
General Practice	10
Hematology	2
Medicine-General	309
Obstetrics & Gynecology	110
Occupational Medicine	4
Pediatrics	100
Pathology	15
Public Health	40

Radiology	48
Radiotherapy	6
Rehabilitative Medicine	2
Surgery-General	262
Venerology	2
TOTAL	**1019**

Source: Medical Board of Trinidad and Tobago

Fees charged by doctors

3.1.10 The representative of the MBTT advised that fees charged by doctors are not regulated in this country. Consequently, there is no fetter on doctors who operate as specialists and charge clients the commensurate fees.

Shortage of Specialist and Subspecialist

3.1.11 Evidence received also highlighted the shortage of doctors within specialties and subspecialties. The MBTT advised that this shortage was linked to availability/accessibility of specialist training programmes locally. The MBTT admitted that it had not made any attempts to address this issue from a policy perspective. However, the MoH indicated that the Ministry of Education (MoE) has been informed of a number of medical specialty areas that require more resources. This intervention was based on a needs assessment. The MoH submitted that the scholarship arrangement is also being improved to avoid the brain-drain of nationals. The MoH through its delivery arm, the RHAs, is seeking to create the requisite positions to absorb the scholars upon their return. Additionally, the Chief Medical Officer (CMO) advised that with IDB funding, the MoH hired a consultant and is in the process of developing a ten (10) year manpower plan for the health sector based on the country's demographics.

The relationship between the MBTT, the RHAs and the MoH

3.1.12 Pursuant to Section 3 of the Medical Board Act, Chapter 29:50, the MBTT is a body corporate. Therefore, it is a separate legal entity from the MoH. However, pursuant to Section 6 of the Act, the Council of the Medical Board is appointed by the Minister of Health and the MoH is represented on the Board through the CMO. In addition, the MoH monitors the operations of the Medical Board through participating in monthly meetings of the Council and the review of Minutes of Meetings of the MBTT.

3.1.13 The MBTT indicated that it maintains a professional and respectable relationship with the RHAs and the MoH and aims to provide requested information to each organization in a timely manner to meet any stipulated deadlines.

Medical Board (Specialist Registration) Regulations 2014

3.1.14 The MoH advised that it formulated policy guidelines for the implementation of the Medical Board (Specialist Registration) Regulations 2014 and it was submitted for the consideration of the MBTT. It was reported that the policy was now before the MoH and once approved the Regulations would be made available on the MBTT's website.

MBTT's main challenges in the execution of its mandate

3.1.15 The Committee attempted to determine the main challenges which were thwarting the success of the MBTT. In this regard, the Committee was advised that these challenges include:

1. obtaining approval from Board Members and the Honourable Minister of Health, as provided for in the Medical Board Act 1960 Section 20(1) and Section 20(2) respectively before implementation rules or regulations; and
2. the high cost of conducting tribunal hearings. An Attorney-at-law is outsourced to provide legal advice for the duration of the investigation. This is done to minimize any adverse cost that is brought against MBTT in the local court upon conclusion/determination of the matter before the Court.

Findings and Recommendations

Based on the evidence set out in the previous section the Committee concluded as follows:

i. Approximately 89% of doctors in Trinidad and Tobago have full registration with the MBTT;

ii. The lack of the payment of the annual fee as prescribed by Sections 14 (2) should be urgently addressed by the MBTT;

iii. It appears that the Council/MBTT adhere to some measure of due diligence when processing applications from doctors who wish to be registered;

iv. A proper system of registering specialist medical doctors in Trinidad and Tobago is long overdue. There has been a notable delay in the operationalization of the

Medical Board (Specialist Registration) Regulations, 2014;

v. There are approximately 1000 doctors who have attained specialist qualification in this country;

vi. Fees charged by medical doctors are unregulated;

vii. The major challenges affecting the efficiency of the MBTT include:

a) bureaucratic delays involved in acquiring ministerial approval and approval from Board members;

b) exorbitant costs associated with retaining the services of legal counsel during Tribunal proceedings.

A. We recommend the immediate implementation of the Specialist Register outlining the respective doctor's qualification which should also be made publicized on the websites of the MBTT and MoH. This register should be adequately maintained and updated as is necessary.

B. We recommend that the list of registered doctors (full, temporary or provisional) should be made accessible to the public via the website of the Medical Board and the Ministry of Health. This will encourage greater transparency in the medical profession.

C. Pursuant to 20 (1)(d) of the Act, we recommend that regulations be made to:

i. provide for an annual fee to be paid by members of the MBTT; and

ii. prescribe penalties for failure to pay such fees.

D. To encourage greater compliance with the proposal made at (C) above, the MBTT should consider publishing a list of doctors who have failed to pay their annual fees. This list can be published once per year on the Board's website and in at least 2 daily newspapers.

E. Due consideration should be given to the costs and benefits of adopting the British model that focuses on a license retention fee as opposed to a license application fee.

F. The Committee endorses the following recommendation proposed by the Trinidad and Tobago Medical Association (T&TMA): "that mandatory registration with the Board needs to be regularised and medical doctors should be held accountable for practicing without a valid registration with the MBTT. Accordingly, sanctions or penalties should be provided for in the Act".

G. To protect the public against unfair pricing, we recommend that the Specialist Register include a prescribed fee structure that must be adhered to by the specialists.

H. Further, we recommend that the Parliament be provided with an update on the policy guidelines for the implementation of the Medical Board (Specialist Registration) Regulations 2014 within 60 days of the presentation of the report.

3.1.16 Based on the evidence received, it was noted that there were some apparent inadequacies with the MB Act. For example, the Committee noted the Board's concerns with Section 20 of the Act which defines the Powers of Council and

denotes that almost any change that the council requires is subject to agreement by the Board and the Minister of Health.

I. **We recommend the thorough review of the Medical Board Act by the Ministry of Health and MBTT in order to:**
   i. **Provide greater autonomy to the Medical Council in the area of decision making.**
   ii. **Reduce the lag time between approvals for decisions to be made.**

Objective 2: The practices and procedures adhered to by the Medical Council in relation to disciplinary proceedings involving medical doctors

3.2.1 Pursuant to Section 24 of the Medical Board Act, the Council of the MBTT has the power and responsibility to discipline its members. The types of complaints frequently made against medical practitioners in Trinidad and Tobago include:

- Issuing dubious sick leave certificate;
- Improper management;
- Unprofessional behavior;
- Ethical misconduct; and
- Advertising.

3.2.2 The MBTT advised that it would have involvement in a matter concerning a complaint against a Board Member once information is brought to its attention. Further, the Committee was informed that the MBTT utilizes a standard procedural format for treating with complaints against registered Board Members

(both national and non-nationals). The steps in lodging a complaint against a medical doctor, were described as follows:

i. the complainant must fill out an official Compliant Form indicating the specific allegations being made against a registered Board Member;
ii. in keeping with the tenets of natural justice, all documents will then be forwarded via courier to the Board Member for a response to be provided within fourteen (14) days of receipt of a letter regarding the allegations contain therein;
iii. Upon receipt of the response from the Board Member, the Council will make a determination at a Regular Monthly Meeting;
iv. In the Regular Monthly Meeting, further action/decision will be made with regard to the matter e.g. whether the matter falls under the purview of MBTT or establishment of a tribunal hearing to hear and inquire into the matter.
v. A small composition of Council Members will hear and inquire into evidence submitted by both complainant and defendant when conducting tribunal hearings. Thereafter, the same composition of council members will also be involved in the disciplinary process.

3.2.3 With regards to the steps involved in lodging a complaint against a medical doctor, the evidence submitted by the T&TMA suggested that the procedure is flawed because the doctor against whom the complaint is made is not mandated to respond to allegations.

3.2.4 The Association also submitted that the timelines involved in the procedure for dealing with complaints from the public should be so structured so as to allow for the issue to be carried to its logical conclusion in a timely manner.

Complaints against a medical doctor in the public sector

3.2.5 The MoH submitted that the avenues for lodging complaints against a medical doctor who operates in the public sector is as follows:

- ***For External Clients:*** Complaints can be lodged through the Suggestion Box or through a Customer Relations Officer attached to the Health Facilities. Complaints can also be lodged with the Quality Department at the RHA. The process for treating with the said complaints is guided by the Client Feedback System Manual.
- ***For Internal Client***: Complaints made are forwarded to the office of the Head of Department/Supervisor attached to the RHA and the process is guided by the RHA's (Conduct), Regulations, 2008. Complaints can also be lodged with the MBTT.

3.2.6 In determining whether to approve the prosecution of a doctor under Section 30 of the Act, the Council will attempt to ensure that all practices/decisions are in keeping with the tenets of natural justice with the assistance of an outsourced Attorney-at-law before a final determination can be made in matters.

Complaints against Foreign Medical Practitioners.

3.2.7 The information submitted by the MoH confirmed that foreign doctors are subjected to the same investigatory process as a local practitioner. However, some allegations of malpractice are investigated in accordance with the MoH's Adverse Events Policy and guidelines (2011).

3.2.8 The MBTT informed the Committee that over the last fifteen (15) years, seven (7) complaints were received against foreign medical practitioners or specialist. The nature of these complaints were:

1. Improper management;
2. False or misleading advertising;
3. Ethical misconduct.

Legal action taken by the Council

3.2.9 It was reported that during the last fifteen (15) years, the Council has not initiated legal matters regarding complaints made against registered doctors. Instead, the Council has taken disciplinary action (reprimand, suspension) against nineteen (19) doctors over the past (15) years of which, one (1) Board Member was removed from the Register of Medical Practitioners on March 7th, 2005 for disgraceful conduct.

Matters of Negligence or Malpractice

3.2.10 Evidence submitted to the Committee indicated that the Medical Board Act does not provide for the Council to adjudicate on matters of negligence or malpractice. Additionally, the Council was unaware of any doctor (national or non-national) that has been found liable for negligence or any other offense in relation to malpractice over the past fifteen (15) years in Trinidad and Tobago. In the instance where the court determines that a doctor was liable for negligence, the Council will be guided by its Attorney-at-law before taking the appropriate action.

Slow rate of disposal of matters before the Council

3.2.11 Members of the Council do not serve on a full-time basis and therefore are not able to dedicate sufficient time to deal with matters because some members also have a full-time practice. As such, meetings are scheduled based on their availability. In this regard, the MBTT indicated that the only means of ensuring the effectiveness of the functioning of the MBTT is to have full-time members serving on the council or at least a segment of the council operating on a full-time basis.

The absence of Insurance Coverage for MBTT members

3.2.12 The MBTT does not have insurance coverage for its members for malpractice and it is not under consideration because it is assumed that doctors are adequately insured otherwise with the Medical Protection Society. Additionally, Private Medical Facilities are not required to have insurance coverage of its medical staff in order to be granted annual licenses to operate. However, it was indicated that some practitioners will have coverage through the T&TMA and other bodies. Appendix IV provides information on the grounds upon which legal action can be taken against the MBTT.

Findings and Recommendations

3.2.13 Based on the evidence set out in the previous section the Committee concluded as follows:

i. There is a standardized operating procedure that is applied in relation to complaints submitted to the MBTT regarding the conduct of doctors. Based on the submission of the T&TMA, it appears that there is a lack of

confidence among some members of the fraternity as it relates to the reliability and robustness of the process.

3.2.14 It was observed that Section 6 of the Medical Board Act stipulates that eight out of eleven members of the Council are required to be medical doctors including the CMO. We concur with the views expressed by the President of the Council that having members of the Medical Council operate on a fulltime basis has the potential of enhancing the efficiency and effectiveness of the Council.

Recommendations

A. We recommend that a Board member against whom an allegation is made be mandated to respond to the allegations within the stipulated timeframe. A doctor should have the option of seeking an extension of time to provide feedback on the complaint. Thereafter, there should be a commensurate penalty for failure to provide a written response to allegations.

B. It is a standard practice that deliberative bodies such as committees and council convene meetings pursuant to an established quorum. In view of this, we recommend that Section 6 of the Act should be amended to stipulate that meetings of the Council be convene based on a quorum of members. Each council should have the authority to determine an appropriate quorum for conducting the council's meetings/proceedings.

3.2.15 The MB Act empowers the Council of the medical board to regulate the registration of medical doctors. It authorizes the Council to take necessary action in response to certain contraventions of the Act. However, the potency of the

Council's investigatory powers in relation to complaints made against medical doctors is dubious. Besides the powers to make "enquires" as provided for in Sections 24, the Council is not vested with any powers, privileges and immunities that would facilitate effective investigations into malpractice or unprofessional conduct of its members. A submission from the T&TMA also highlighted the fact that the MBTT lacked investigative powers.

3.2.16 The Committee also took note of the procedural guidelines set out in the MoH and the Pan American Health Organisation's Adverse Events Policy and Guidelines (2011)[4]. Although it appears that these guidelines are applicable to doctors operating in the public and private sector, it was observed that the Medical Board or Council is not involved in the stakeholder matrix that encompasses investigations into Adverse Medical events. The guidelines appear to omit the Medical Council as a consumer or recipient of reports on adverse events.

3.2.17 Furthermore, a submission from a stakeholder also indicated that the MBTT is powerless to act against non-medical doctors, such as persons who practice osteopathic, naturopathic or homeopathic medicine or those in the allied health professional fields whose actions and false advertisements knowingly harm the health of the public.

C. We therefore recommend that an investigative arm of the Board should be commissioned in conjunction with the Director of Public Prosecutor's (DPP) office.

[4] www.health.gov.tt/downloads/DownloadItem.aspx?id=247

D. The Committee recommends that the Ministry of Health pursue stakeholder consultations regarding the appropriate modalities for a robust and effective system for conducting investigation into complaints made against medical practitioners. The system should:

- **a. Promote fairness and equality in the investigative process;**
- **b. Afford the medical board sufficient powers to initiate or support such investigations;**
- **c. Take into consideration existing policy guidelines that aim to threat with allegation of inappropriate conduct by medical doctors;**
- **d. Empower the Council to "send for papers and records" pertinent to any investigation into the conduct of medical doctors.**

E. We recommend that the Ministry of Health present to the Parliament a policy position on the regulation of allied health professionals (not inclusive on nurses) in Trinidad and Tobago within three months of the presentation of this report.

F. The policy position should also include the establishment and maintenance of a register of qualified allopathic doctors as is done by the General Medical Council, UK.

3.2.18 We noted the response of the MoH that insurance coverage as a requirement for granting a license to operate as a medical practitioner can be developed through regulations and enforcement.

Objective 3: Criteria, Standard and Procedures in place for the hiring of foreign doctors and Monitoring their Performance

Criteria, standard and procedures for the recruitment of foreign doctors

3.3.1 The recruitment of doctors (both national and non-nationals) falls under the purview of the MoH while the MBTT is responsible for the registration and disciplining of doctors.

Nationals and Non-Nationals registered under the MBTT

3.3.2 The table below illustrates the number of nationals and non-nationals registered under the MBTT as at October 2016.

Table 3:
Number of Nationals and Non-Nationals

REGISTRATION STATUS	NATIONALS	NON-NATIONALS
Provisional Registration	303	31
Temporary Registration	81	159
Full Registration	3,371	1,650
Total	3,755	1,840

Source: Medical Board of Trinidad and Tobago

3.3.3 During the inquiry, it was indicated by the MBTT that there are currently 1,209 foreign medical practitioners practicing medicine in Trinidad and Tobago. The main countries of origin are:

1. Nigeria;
2. India, and
3. Cuba

3.3.4 The Ministry employs foreign doctors when there is a shortage of local doctors in certain specialty areas. According to evidence received from the MBTT, a foreign medical doctor who wishes to practice in Trinidad and Tobago is granted temporary registration for a maximum of three (3) years and must:

a) have the ability to speak the English language;
b) have a valid job offer from a local RHA; and
c) submit the following documentation:
    - original certified copies of their medical degree, postgrad qualifications and an original certified copy;
    - a letter of good standing from their current registration body which must not be more than three months old;
    - a certified copy of their current license to practice in their jurisdiction; and
    - a certified copy of an identity for their passport.

3.3.5 The MoH's eligibility verification processes involves:

i. the thorough examination of certificates to ensure that they are not counterfeits; and
ii. regionally through CARICOM, the Caribbean Association of Medical Councils (CAMC) requires graduates from foreign medical schools to undergo an exam to qualify for registration which is a requirement for registration in Trinidad and Tobago.

3.3.6 Subsequent to getting into the system, an assessment is conducted by the respective supervising doctor annually as a requirement to retaining the temporary license. Once the assessments have been passed for the three (3) years under the temporary license, the next step entails the process for obtaining full registration.

3.3.7 Foreign doctors are only allowed to work in institutions where they can be closely monitored such as General Hospitals, area hospitals and certain district health facilities. The MoH advised that foreign doctors generally serve in senior positions such as registrar and specialist levels.

Parallel Medical Board

3.3.8 A parallel medical Board was created via amendment to the Medical Board Act in 2007 in response to shortages in the public health system and involved the hiring of over 2,000 foreign doctors to fill vacancies in the short term. However, there were issues with the timely licensing of these doctors by the MBTT and as a result, it was ended.

Findings and Recommendations

3.3.9 Based on the evidence set out in the previous section the Committee concluded as follows:

i. Approximately forty-nine percent (49%) of doctors holding full registration with the MBTT are non-nationals. Submissions received from stakeholders, suggest that the increase in the foreign cohort of doctors in Trinidad is in part attributable to the work of the now defunct parallel medical board that allowed over 2,000 foreign doctors to be registered to practice in the public health system. However, the Committee remains concerned that not all of these foreign doctors were registered with the MBTT. It is also of concern to the Committee and the respective stakeholders that the MBTT had no means of dealing with this problem as it only has control over those doctors who are registered with the MBTT save if a complaint is brought to its attention.

ii. that foreign doctors are required to satisfy conditions of registration which are equal or similar to nationals and that the MoH and the MBTT undertake certain due diligence processes to ensure the authenticity of credentials of foreign doctors. In this regard, the Committee was satisfied with the criteria, standards and procedures for recruiting non-nationals.

3.3.10 However, we noted a concern raised by the T&TMA highlighted that non-nationals who wish to register solely for private practice should meet the full accreditation eligibility requirements of the MBTT.

A. Creating or facilitating any alternative mechanisms for registering medical doctors besides the medical board may have a deleterious effect on status and authority of the MBTT. Arguably, alternative mechanisms for screening doctors seeking registration in Trinidad and Tobago can employ the same criteria and due diligence process of the Medical Council. However, strengthening and

supporting the operations of a single oversight body (i.e. MBTT) would promote greater control and certainty in the regulatory framework. In view of this, we recommend that the MBTT in collaboration with the MoH implement a strategy to ensure that all non-nationals are registered with the MBTT.

Objective 4: Systems in place to protect patients against malpractice by doctors

Protection available to public from malpractice

3.4.1 Persons who have been victims of alleged malpractice may lodge a complaint with the MBTT/Medical Council. In terms of compensation, the courts and legal system will determine the final course of action to be taken.

Malpractice Register

3.4.2 It was noted that the existing MB Act does not provide for a "Malpractice Register". As a consequence, to establish such a register the MB Act must be amended. The MoH indicated that consideration is being given to develop a malpractice register.

Developing a "whistleblowing" mechanism to facilitate anonymous complaints against medical doctors

3.4.3 The Act does not make any provision for a "whistleblowing mechanism" through which complaints against medical doctors can be lodged. However, page 19 of the MBTT's Code of Ethic to which all doctors are supposed to subscribe states that:

"• *Patients must be protected from a colleague whose conduct, competence or health is questionable. The concern raised should be dealt with expeditiously, and must*

override personal or professional loyalties." and,

- *Where there is a suspicion that criminal activity has taken place, and in particular in cases of alleged sexual assault, a police report must be made."*

Code of Ethics for medical doctors

3.4.4 The Committee was advised that all medical doctors and all new applicant(s) are guided by a Code of Ethics which can be sourced on the MBTT's website. In addition, all doctors are required to indicate on MBTT's application form that they have reviewed the Code of Ethics before finalization of registration with MBTT.

Systems in place to ensure that medical practitioners are aware of and adhere to international best practices

3.4.5 The MoH through Continuous Medical Education (CME) via workshops and seminars ensures that medical practitioners are aware of and adhere to international best practices. Furthermore, the MoH invested heavily in *infoMedPlus* which is an e-medical portal through which all doctors can access the latest medical research via thousands of e-medical journals, a full Nursing reference center and databases of infectious diseases and epidemiology. The MoH also circulates/distributes Policy Documents for guidance to adhere to international best practices at both private and public hospitals.

Continuing Medical Education (CME)

3.4.6 The MBTT advised that it has no specific role in encouraging doctors to pursue CME in accordance with Section 20(1) (j) of the Act which provides for a voluntary system of CME. The MBTT does not provide financial assistance to doctors to

pursue additional studies. The following amendment to the Act was proposed by the MBTT as a means of encouraging doctors to encourage in CME:

(Section 14 (3))*"The person, upon being granted registration, in order to pay Annual Retention Fee as prescribed in subsection (2), will be required to show evidence of Continuing Medical Education (CME) credits, in accordance with the standards prescribed in CME regulation".*

3.4.7 Based on the responses received from the MoH concerning this matter, it was indicated that the MoH together with the RHAs has arranged a number of training programmes, seminars as well as workshops for doctors. Doctors are also encouraged to pursue CMEs through a Continuing Medical Education Allowance which is available to all three (3) categories of Medical Doctors in the RHAs: Specialist Medical Officer (S.M.O.) Registrar/ Medical Officer I/ Primary Care Physician II and House Officers.

Proposed Regulations for CME credits

3.4.8 The MBTT also submitted the following prescribed CME credit points required to be eligible for the payment of Annual Retention Fee as per Section 14 (3):

- *General Registration-* all temporary and fully registered practitioners must produce documentary evidence of CME activity. Such evidence shall consist of 10 CPD credit points per annum and which are recognised by the MBTT.
- *Special Registration-* at the end of five years from the date of entry into the Medical Specialist Register, a specialist must produce documentary evidence of appropriate continuing professional development to maintain his/her status in the Specialist

Register. Such evidence shall consist of 12 CME credit points per annum for the first five years and thereafter 18 credit points per annum in the respective specialty area. Such evidence may be submitted annually to the MBTT for their confirmation.

Performance Appraisal of Medical Doctors

3.4.9 The Committee was informed that Medical Officers are appraised on an annual basis in alignment with their contact periods. Holders of temporary registration (a temporary licence for one (1) year) employed at public health facilities are required to have their respective consultants complete MBTT's confidential Recommendation Form and submitted on a quarterly basis in order to be considered for a further one (1) year temporary registration with MBTT.

Findings and Recommendations

3.4.10 Based on the evidence set out in the previous section the Committee concluded that:

i. MBTT does not maintain a Malpractice Register; and

ii. there is need for regular monitoring of the performance of Doctors (particularly junior doctors).

A. We concur with the T&TMA's suggestion that the Medical Council include in its draft legislation, provisions for the creation of a malpractice register. The proposed amendment to the MB Act must also prescribe that this list shall be published along with a Register of doctors in good standing. We believe that such an arrangement would promote more transparency in the medical profession. This along with other

amendments to the Act should be submitted for the consideration/concurrence of the Minister of Health by the end of fiscal 2016/2017.

B. Information on conduct/actions which may amount to a malpractice by a medical doctor should also be widely published/disseminated.

3.4.10 We learned that CME is a practice adhered to by the World Medical Association (WMA) and GMC of the UK. We noted that the MoH has partnered with foreign institutions to offer training for doctors locally. However, there is need to expand this initiative to accommodate CME.

C. We recommend that all doctors be required to provide the MBTT with documentary evidence of CME activity biennially in order to maintain general registration. To address this issue, we suggest that Section 20 of the MB Act should be amended and submitted for the consideration/concurrence of the Minister of Health by the end of fiscal 2016/2017 with other amendments recommended by the MBTT.

D. We also recommend that the MBTT:

i. set out the framework of principles and behaviours that should guide CME activities in the form of a handbook for all doctors similar to that of the GMC's Continuing Professional Development Guidance for all doctors; and

ii. raise awareness about trends, issues or opportunities that may be relevant to CME for the guidance of doctors via an annual bulletin that should be

published on both the MBTT's and MoH's websites.

E. We recommend that the MoH utilise its partnership with foreign institutions to provide training for doctors locally to assist in fulfilling the requirements for CME.

3.4.11 The Committee noted the evidence provided by the T&TMA that "Doctors are also asked to complete a Certificate of Good Character as part of the requirements for registration." Additionally it was noted that doctors who are employed in the public health institutions, as a team effort regulated by the RHAs are encouraged through morbidity and mortality meetings, performance evaluations and audit of service to maintain good character. However, the MBTT has no authority to request the same of private institutions or practitioners.

F. In this regard we recommend that the MBTT collaborate with the MoH to establish a mechanism for monitoring and evaluating foreign doctors who are engaged in private practice. These methods might include compulsory periodic reports or activities of foreign doctors; the establishment of a functioning complaint service for patients; independent community surveys using cheap methods such as citizens' score cards (Brixi 2009) or social audits; occasional key informant interviews or focused group discussions on doctors' behaviour.

Other matters highlighted during the inquiry

Forensic pathologists

3.5.1 The Committee sought to determine what was being done to address the acute

shortage of practitioners in the area of Forensic Pathology. The Committee was informed that scholarship recipients in the area of forensic pathology are absorbed by the Ministry of National Security (MoNS). Doctors employed with the MoH also provide *medi-call on-call* [5]services on behalf of the MoNS for persons who died by suicide, sudden death, or natural causes. The MoH continues to advertise and offer scholarships to foreign institutions for advanced and sub-speciality training in forensic pathology through negotiation with the MoE because such training is not offered at the local universities. The UWI provides training in general pathology.

Terms and conditions of employment within the public health sector

3.5.2 During the public hearing, the Committee was advised that the current health system in Trinidad and Tobago allows doctors to work simultaneously in the public and private sectors.

3.5.3 The MoH and the RHAs are responsible for confirming whether a medical doctor employed in the public health sector can establish/maintain a private practice simultaneously. Subject to the terms and condition of a doctor's contract, once full registration status is granted by the MBTT and the required contractual work hour obligation in the public system has been satisfied, a doctor is permitted to establish and or maintain a private medical practice.

3.5.4 The MBTT informed the Committee that the mixed system emanated from an agreement made with the PSA since 1976 where it was recognised that the MoH could not afford to pay specialists. A trade-off was made for a private practice with

[5] Medical call service

the condition that doctors should manage their respective units and be available when emergencies occur.

Findings and Recommendations

3.5.5 The Committee noted that there is a strong supply of doctors at the entry level but a deficiency at the specialist levels. Consequently, doctors are still being recruited from other jurisdictions to fill vacancies. The Committee was encouraged to learn that the MoH is pursuing training programmes and scholarships to assist in filling these vacancies. Moreover, the Committee was pleased that the MoH in collaboration with the MoE is seeking in-house training through the local universities and foreign partnerships rather than sending scholars abroad for training which is becoming challenging.

3.5.6 However, despite the multifaceted and multifactorial approach being taken to treat with the deficiency in specialist doctors, the Committee is concerned about this country's ability to fully recompense specialised doctors and to retain them in this country particularly in the public health system.

3.5.7 The Committee notes that the mixed system that currently exists is the result of the inability to pay specialist and as a result, one of the inherent risks is that doctors operating this dual service may be providing an inadequate amount of hours of work in the public health system. In this regard, we concur with the implementation of a time record management system for doctors employed in the public health system as a measure to hold them accountable for the required

number of hours of work daily/weekly at a public health care facility. We also noted that the mixed system require further deliberation by the government.

A. We recommend that consideration be given to the implementation of an automated time record management system for doctors employed in the Public Health System.

3.6.1 The Committee respectfully submits the foregoing for the consideration of the Parliament.

H.R. Ian Roach
Chairman

June 28, 2017

Appendices

Appendix I

Minutes

MINUTES OF THE 10TH MEETING OF THE JOINT SELECT COMMITTEE APPOINTED TO INQUIRE INTO AND REPORT ON LOCAL AUTHORITIES, SERVICE COMMISSIONS, STATUTORY AUTHORITIES (INCLUDING THE THA) HELD IN THE ARNOLD THOMASOS ROOM (EAST), LEVEL 6, OFFICE OF THE PARLIAMENT, TOWER D, 1A WRIGHTSON ROAD, PORT OF SPAIN HELD ON FRIDAY NOVEMBER, 11 2016 AT 9:27AM

PRESENT

Members

Mr. H. R. Ian Roach	Chairman
Ms. Ramona Ramdial, MP	Vice-Chairman
Mrs. Jennifer Baptiste-Primus	Member
Mr. Nigel De Freitas	Member
Mr. Daniel Solomon	Member

Secretariat

Mr. Julien Ogilvie	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Ms. Ashaki Alexis	Parliamentary Intern

ABSENT

Mr. Stuart Young, MP	Member (Excused)
Mr. Faris Al-Rawi, MP	Member (Excused)
Mr. Darryl Smith, MP	Member

Also present were:

Officials of the Medical Board of Trinidad and Tobago

Prof. Terrence Anand Seemungal	President of the Council

Officials of the Ministry of Health

Mr. Richard Madray	Permanent Secretary
Ms. Dianne Dhanpath	Deputy Permanent Secretary
Dr. Akenath Misir	Chief Medical Officer
Mr. Asif Ali	Health Sector Advisor
Mrs. Mala Kowlessar-Tagallie	State Counsel III (Ag.)
Mr. Lawrence Lalsingh	Director, Health, Policy, Research and Planning

Officials of the National Insurance Property Development Company

Mr. David Benjamin	General Manager
Ms. Marissa Austin	Head of Pharmaceutical (Ag.)

CALL TO ORDER

1.1 The Chairman called the meeting to order *(in camera)* at 9:27am.

1.2 The Chairman informed Members that Mr. Young and Mr. Al-Rawi requested to be excused from the meeting.

CONSIDERATION OF THE MINUTES OF THE 9th MEETING HELD ON SEPTEMBER 28, 2016

2.1 The Chairman asked Members to examine, page by page, the Minutes of the Meeting held on Wednesday September 28, 2016.

2.2 There being no corrections or omissions, the Minutes were confirmed on a motion moved by Ms. Ramdial and seconded by Mrs. J. Baptiste-Primus.

MATTERS ARISING FROM THE MINUTES

3.1 The Chairman referred the Committee to:

- **Item 4.5 on page 2:** He informed Members that the Committee's First Report on the Land Settlement Agency was presented in the House of Representatives on Wednesday November 09, 2016 and will be presented at the next Sitting of the Senate to be held on Tuesday November 15, 2016.

- **Item 5.2 on page 3:** The additional information requested by Ms. Ramdial from the THA and the Port Authority was received and circulated to Members via email on Friday November 04, 2016.

- **Item 6.2 on page 3:** The written responses from the Medical Board of Trinidad and Tobago in response to the Committee's pre-hearing inquiries were circulated to Members on November 01, 2016.

CONSIDERATION OF THE DRAFT INQUIRY PROPOSAL ON THE STRATEGIC SERVICES AGENCY (SSA)

4.1 The Chairman reminded the Committee that the draft inquiry proposal was circulated to Members for consideration and comments on the evening of November 10, 2016.

4.2 It was acknowledged that Members did not have sufficient time to consider the draft. As such the Chairman granted Members and additional seven (7) days to consider and comment on the Inquiry Proposal.

4.3 The Chairman then invited Members to consider and confirm the objectives of the Inquiry. The Committee subsequently agreed to the objectives stated in the draft.

CONSIDERATION OF THE DRAFT SECOND REPORT ON AN INQUIRY INTO CERTAIN ASPECTS OF THE ADMINISTRATION OF THE THA

5.1 The Chairman reminded the Committee that the revised draft report was circulated to members for further consideration and comments on November 04, 2016, but to date no comments were submitted.

5.2 Mr. Solomon indicated that certain issues were not highlighted in the report and proposed that the report be amended accordingly. The Committee agreed that the following matters should be included in the Report and the respective recommendations be made to address same:

- the inadequate budgetary allocation for marketing Tobago as a viable tourist destination;
- the need for the re-establishment of the Airlift Committee;
- the perennial problem of the air bridge and its effect on the consumers;
- the lack of collaboration between the THA, TDC and the THTA; and
- the shortage of workers to support the tourism and hospitality industry in Tobago.

5.3 After some discussion on the failure of Caribbean Airlines to improve the air bridge between Trinidad and Tobago. The Committee agreed that Caribbean Airlines Limited should be invited to a public hearing on November 30, 2016 at 9:30 am to respond to the many issues affecting passengers travelling between the two islands.

PRE-HEARING DISCUSSIONS ON THE INQUIRY INTO THE LICENSING AND REGULATION OF MEDICAL DOCTORS BY THE MEDICAL BOARD OF TRINIDAD AND TOBAGO

6.1 The Chairman advised Members that officials from the MBTT, Ministry of Health and NIPDEC are expected to appear before the Committee.

6.2 The Chairman indicated that copies of the following documents were circulated to all Members:

a. Pre-hearing submissions of the Medical Board and the Ministry of Health;
b. Stakeholder submissions from the;
    - Trinidad and Tobago Medical Association;
    - Trinidad and Tobago Registered Nurses Association;
    - Dental Council of Trinidad and Tobago;
    - A submission from Dr. Hughvon Des Vignes, Pathologist;

c. Issues Papers based on the submissions of the Medical Board and the Ministry of Health.

6.3 There being no further business for discussion the Chairman suspended the meeting at 10:06 a.m.

PUBLIC HEARING WITH OFFICIALS OF THE MBTT, THE MINISTRY OF HEALTH AND NIPDEC

7.1 The Chairman reconvened the meeting *(in public)* at 10:17 a.m.

7.2 Introductions were made.

7.3 The Chairman highlighted the objectives of the inquiry and acknowledged the submissions that the Committee received.

Opening Statements

8.1 The Chairman invited Prof. Seemungal, President of the Council of the Medical Board to make a brief opening statement. He informed the Committee of the following –

- that he assumed the post of President of the Council in December 2015;
- that other members of the Council were unavoidably absent;
- that the correction to the Board's submission was made via letter dated November 04, 2016; and
- that there are no medical specialists registered by the Medical Board in Trinidad and Tobago.

8.2 The Chairman then invited the Permanent Secretary (PS), Ministry of Health to make a brief opening statement. The Permanent Secretary gave an overview of the Ministry's role and responsibility in relation to the Medical Board of Trinidad and Tobago and the health sector.

8.3 The Chairman then invited the General Manager of NIPDEC to also make a brief opening statement. Mr. Benjamin informed the Committee that NIPDEC's role is to procure wholesale pharmaceuticals for the health sector.

8.4 The following issues arose from the discussions held with the officials of the MBTT, the Ministry of Health and NIPDEC:

i. **The Failure of the MBTT to implement a Specialist Register**

a. The Committee sought to determine the reasons for the failure to implement a Specialist Medical Register. The PS, Ministry of Health advised that although the MBTT Act provides

for the establishment of a Specialist Register, there has been some difficulty in finalising the criteria for the Register. However, in 2014 the regulations were made and the Ministry completed a policy on the implementation of the Regulations which is currently under review and is awaiting consensus of the Board.

a. The Committee further questioned the officials to ascertain whether there are medical practitioners in Trinidad and Tobago who claim to be specialists. The President of Council informed the Committee that this is correct and the reason for this may be that some doctors are registered/qualified as specialists in other jurisdictions such as the UK and North America. He also stated that a doctor can conduct the duties of a specialist practitioner but cannot advertise or misrepresent himself as such unless he is recognized as a specialist.

b. Members enquired whether the MBTT has made any attempt to prevent medical practitioners from advertising as Specialists and charging fees to the equivalent. The President advised that there is no regulation with regard to the fees doctors charge.

ii. **Doctors Practicing Medicine Without Renewing their Licences**

a. The President of the Council advised that the Act stipulates the procedure for registering as a medical practitioner but does not address the issue of licence renewal. As such, there is no procedure to remove a doctor's name from the list of registered doctors for failing to pay the requisite fees. The President informed the Committee of the practice observed in other jurisdictions, such as the UK, where doctors are not required to pay an initial registration fee but rather an annual registration fee and failure to pay this annual renewal fee within a stipulated period would result in your name being removed from the Register.

b. Official were asked to comment on the status of the claim made by the Medical Association in a submission to the Committee. The Association claimed that there are approximately 1, 200 foreign medical practitioners employed in Trinidad and Tobago who have temporary licences and there are some whose license has expired but continue to work in the public health care system. The President admitted he is not certain of the number of unregistered foreign doctors but that 1, 209 foreign doctors are registered with the Board.

c. The President of the Council advised that a proposal was made to amend the MBTT Act to address the issue of unregistered doctors.

iii. **Malpractice Insurance Coverage for Doctors**

a. The Chairman enquired whether the MBTT has malpractice insurance coverage for its members. The President of the Council advised that doctors independently secure malpractice insurance coverage with the Medical Protection Society.

b. He also enquired whether it is mandatory for private medical institutions to have liability insurance coverage. The CMO indicated that it was not a requirement but through the T&T Medical Association and other organisations doctors have insurance. However, doctors operating in the public sector are covered through vicarious liability.

iv. **What protection does a patient have against Medical Negligence?**

a. The CMO advised the Committee that a compliant can be made against a practitioner to the Board, then the matter is referred to the Council to be investigated. Compensation will be determined by the Court.

b. The Chairman sought to ascertain the reason(s) that in 15 years, only one litigant's case was successfully prosecuted, in light of the numerous cases of malpractice that have occurred over the years. The President informed the Committee that the Act of 1960 does not allow the Council to adjudicate on matters of negligence or malpractice, those matters are determined by the Court. The Council adjudicates on matters of infamous or disgraceful conduct for which there was only one erasure.

v. **The Failure of the MBTT to implement a Malpractice Register**

The Committee questioned the officials on the factors that caused the Board to not implement a Malpractice Register. The Council's President advised that the Act has not been amended to introduce such a register. However, the Legal Counsel from the Ministry of Health stated that once the Board submits the necessary recommendations for an amendment of the Act, the Ministry would review and make the necessary arrangements to initiate the process of getting the Act amended.

vi. **Continuous Medical Education (CME)**

The Committee sought an update on the role of the Board in encouraging its members to pursue CMEs. The President informed Members that the Board has agreed in principle for doctors to earn CME credits. However, the Ministry encountered some issues and the document was returned to the Board. Prof. Seemungal also highlighted the fact that the Board cannot force its Members to pursue CMEs because it is not stipulated in the Act.

vii. **Training for Doctors in Specialised Areas of Medicine**

a. Based on the MBTT's submission, the Chairman noted that there were a number local doctors in the health sector but very few specialists. Prof. Seemungal advised that there is a shortage of doctors holding qualifications in subspecialties in critical fields of medicine, for example; cardiology and gastroenterology. He further advised that the Board is not responsible for funding training programmes or the award of scholarships.

b. The CMO was asked to comment on the measures taken by the Ministry to address this concern. He advised that his Ministry has engaged the Ministry of Education in discussions and have identified a number of areas for specialized training at foreign universities based on a needs assessment of the country. He further explained that in the past when local doctors receive specialised training abroad, they are hired by the foreign medical institutions which has led to a 'brain drain'. However, both the Ministries of Health and Education are working on a bonding arrangement to ensure locally trained doctors return to this country to practice. He also mentioned that the Ministry is looking at different options, previously the Ministry through the University of Trinidad and Tobago offered a postgraduate specialty programme in cardiology with consultants from John Hopkins University.

viii. **Issues that Prevent Specialist Doctors from Practicing Medicine in Trinidad and Tobago**

The Chairman enquired whether the MBTT or the Ministry of Health was able to provide the reasons local doctors who have practiced in other jurisdictions as specialists encounter barriers when they seek to practice in Trinidad. The President of the MBTT indicated that he is aware of the issue and he has received complaints but cannot state the reasons for the problem. The CMO also admitted that he was aware of the situation but cannot provide a reason for it.

ix. **The Lack of Opportunities for Young Doctors to Access Specialised Training**

a. The Chairman enquired about the reasons young doctors and Registrars are unable to access specialized training. The President of the MBTT identified two reasons:
   - The high cost of training overseas;
   - Lack of local training programmes offered by the UWI.

b. The Chairman further enquired whether the process for the selection of doctors was objective. The President of the Council indicated that in most cases for a doctor to be

trained in specialist areas such as rehabilitative medicine or palliative care, a doctor would have to apply in open competition with other foreigners. The competition for spaces also increased when England became a full member of the EU which made it difficult for local doctors to gain entry into U.K. training programmes.

x. **The Shortage of Doctors at Public Health Institutions**

a. The Committee questioned the officials regarding the claim that there is a shortage of doctors at public health institutions, this issue was raised in the submission from the Trinidad and Tobago Registered Nurses Association. The officials advised the Committee that the issue is not a shortage of doctors but rather a shortage of specialists and subspecialists. The Ministry of Heath has sought to address this issue through IDB funding; development of a 10-Year Manpower Plan for the health sector; and scholarships for doctors in specialized areas.

b. The Committee questioned whether the reason for the shortage of specialists in the public health sector was due to the fact that specialist gravitate to the private sector in search of more favorable earnings. The PS, Ministry of Health informed the Committee that this issue was considered by a Committee commissioned by the Prime Minister to review the delivery of health care through the RHAs. Although the issue was identified, the Executive appointed Committee was unable to provide a comprehensive recommendation to resolve the issue, as a result it is still under review.

c. The President of the Council sought to provide a historical background on the rationale for doctors working in both the public and private medical institutions. In 1976 the Public Service Association (PSA) negotiated on behalf of the doctors for an arrangement where the specialists in the public sector can also work in private institutions since the Ministry could not afford to pay doctors a specialist salary.

d. The Committee also enquired about the impact the presence of foreign doctors in public health institutions was having on the ability of local doctors to access jobs. The PS, Ministry of Health informed the Committee that foreign doctors are not hired to fill junior positions (House Officer) but to fill the vacant Specialists positions.

xi. **The shortage of Forensic Pathologists in Trinidad and Tobago and the effect on combatting Crime**

The CMO explained that Forensic Pathologists are hired by the Ministry of National Security and not the Ministry of Health. He advised the Committee on the distinction between the duties performed by pathologists and the forensic pathologists.

xi. **The Verification of Doctors' Degrees and Certificates**

a. The Committee enquired about the procedure used by the Medical Board to authenticate the degrees and Certificates submitted by doctors seeking to be registered. In his response, the President of the Council stated that original Certificates are requested from the traditional medial schools and if the documents are from a non-traditional university the Board will seek to confirm whether the university is accredited through the Accreditation Council of Trinidad and Tobago and if the school is listed on the World Directory of Medical Schools.

b. The Committee enquired whether Trinidad and Tobago would implement "medical Board Exams" as a means of qualification for foreign doctors. The CMO explained that there is a regional exam issued by the Caribbean Association of Medical Councils for foreign doctors requesting to practice in the Caribbean.

xii. **The Role of NIPDEC in the Procurement of Pharmaceuticals for the Public Health System**

a. NIPDEC is the sole procurer of pharmaceuticals for the health sector in Trinidad and Tobago. The Corporation is also responsible for the storage and distribution of the drugs to the Regional Health Authorities. The drugs are procured through a tender process. The pricing structure of drugs are generally determined by the manufacturers who are based mostly in the First World countries. The quality and types of drugs purchased by NIPDEC is determined by the list of registered drugs approved by the MoH (formulary). Although some generic drugs maybe a cheaper alternative, if the drug is not legally authorised it cannot be purchased.

b. The General Manager of NIPDEC advised the Committee that the approved list of drugs comprised approximately 1000 items. Whereas, in larger jurisdictions the list has 300 approved drugs. The Ministry has embarked on an initiative to reduce the figure by not purchasing various brands of the same drug; reduce the number of branded drugs purchased; and to better utilise generic drugs.

c. An arrangement to procure drugs through the Pan-American Health Organisation (PAHO) is under review by the Ministry of Health.

xiii. **Expired Drugs Stored by NIPDEC**

a. The value of expired drugs stored by NIPDEC for the last five years was $63 Million. The reasons for this were:

- NIPDEC is unable to determine the level of inventory within the RHAs at any particular time;
- The RHAs do not follow the instructions of the Evaluation Committee; and
- Certain generic drugs are not used often by the Health Institutions resulting in expired drugs.

b. NIPDEC submitted that in order to reduce the wastage a *WhatsApp* group was developed to communicate with the various pharmacists and to coordinate the distribution of certain drugs.

xiv. **Shortage of Lifesaving Drugs**

The Committee enquired about the shortage of drugs to treat cancer at public health facilities. The General Manager informed Members that the reason was due to the delay in the release of funds to purchase the drugs; the failure of the health institutions to indicate when the drug supply is low and the lengthy time period associated with procuring the drugs.

xv. **Whistleblower Protection**

The Committee sought to ascertain whether any proposed amendments were made to the Act to protect whistleblowers. The President of the Medical Council informed the Committee that there are provisions in the Code of Ethics for "Whistleblowing" against errant medical practitioners. However, the Committee recommended that if such provisions are placed in the legislation it will be more effective.

8.5 The Chairman then invited the President of the Council, the Permanent Secretary and the General Manager to make closing comments.

Request for additional information

9.1 The MoH was requested to provide a written response to the following question:

- What mechanisms are in place to prevent doctors from utilizing resources allocated to public health facilities to support/aid their private practice?

ADJOURNMENT

10.1 The Chairman thanked all present for attending and the viewing and listening audience. He also informed the public that the Committee's first report on the Land Settlement Agency was tabled and will be available on the Parliament's website.

10.2 The meeting was adjourned at 12:23 p.m.

I certify that the Minutes are true and correct.

Chairman

Secretary

November 24, 2016

Appendix II

Verbatim Notes

VERBATIM NOTES OF THE TENTH MEETING OF THE JOINT SELECT COMMITTEE APPOINTED TO INQUIRE INTO AND REPORT ON LOCAL AUTHORITIES, SERVICE COMMISSIONS STATUTORY AUTHORITIES (INCLUDING THE THA), HELD IN THE ARNOLD THOMASOS ROOM (EAST) MEETING ROOM, SIXTH FLOOR (IN CAMERA) AND (IN PUBLIC) IN THE J. HAMILTON MAURICE ROOM, MEZZANINE FLOOR, TOWER D, INTERNATIONAL WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON FRIDAY, NOVEMBER 11, 2016 AT 9.27 A.M.

PRESENT

Mr. H. R. Ian Roach	Chairman
Miss Ramona Ramdial	Vice-Chairman
Mrs. Jennifer Baptiste-Primus	Member
Mr. Nigel De Freitas	Member
Mr. Daniel Solomon	Member
Mr. Julien Ogilvie	Secretary
Miss Khisha Peterkin	Assistant Secretary
Miss Ashaki Alexis	Parliamentary Intern

ABSENT

Mr. Faris Al-Rawi	Member [*Excused*]
Mr. Stuart Young	Member [*Excused*]
Mr. Darryl Smith	Member

Mr. Chairman: Good morning, ladies and gentlemen. Good morning members of the public. We are starting a bit late. We kept back a bit doing a little housekeeping, and we do apologize, but hopefully we would lose no further time in conducting our affairs this morning. Welcome to the viewing and listening audience, to the 10th meeting of the Joint Select Committee on Local Authorities, Service Commissions, Statutory Authorities, including the Tobago House of Assembly. This morning's Committee will hold a public hearing with officials of the Medical Board of Trinidad and Tobago and the Ministry of Health and also Nipdec.

This hearing is being convened for this Committee's current enquiry into the regulations and licensing of medical doctors by the Medical Board of Trinidad and Tobago. My name is HR Ian Roach, I am the Chairman of the

Committee and I will invite other members to introduce themselves, starting on my right, Vice-Chairman.

[*Introductions made*]

Mr. Chairman: I will also like to welcome the members of the Medical Board of Trinidad and Tobago, the Ministry of Health and NIPDEC. I will also like to welcome the stakeholders who are here to participate or at least witness and observe this public hearing.

I will start with the Medical Board of Trinidad and Tobago. Could members please introduce themselves?

[*Introductions made*]

Prof. Seemungal: I would like to apologize to the Joint Select Committee, the other members who should have been here have not so far appeared, and I can say that Mrs. Suite has a court matter which is why she is not here. She called to tell me.

Mr. Chairman: There is somebody else missing. Mr. Anthony Pierre as well?

Prof. Seemungal: Mr. Pierre is not here.

Mr. Chairman: What is the reason he is not here?

Prof. Seemungal: I have not received any communication from him as yet.

Mr. Chairman: So he may be coming still?

Prof. Seemungal: He may, yes.

Mr. Chairman: Ministry of Health.

[*Introductions made*]

Mr. Chairman: NIPDEC.

[*Introductions made*]

Mr. Chairman: Let me just remind all present this morning of the objective of this enquiry. One is to understand the systems and procedures employed by the Medical Board and its Council to execute its mandate. Two, to assess the practices and procedures adhered to by the Medical Council in relation to disciplinary proceedings involving medical doctors. Three, to assess the criteria, standards and procedures in place for hiring foreign doctors and monitoring their performances. To assess the systems in place to protect patients against malpractice by doctors.

I would like to acknowledge and thank those submissions received from the Medical Board of Trinidad and Tobago, the Ministry of Health, Trinidad and Tobago Medical Association, the Trinidad and Tobago Registered Nurses Association, the Dental Council of Trinidad and Tobago and from Dr. Hughvon Des Vignes, pathologist.

I will now invite the President of the Medical Board of Trinidad and Tobago, Prof. Terrence Seemungal, to give a brief opening statement to the Committee.

Before you proceed, when speaking please use your microphone, put it on in order that your voice may be captured by the CAT Reporters. Thank you very much.

Prof. Seemungal: Thank you, Chairman, and we would like to thank the Joint Select Committee for the invitation to appear before you this morning. I would like to just let you know that I have been President since December2015. The Council has attempted to answer, as extensively as we could, all of the detailed questions asked of us by the Committee. We had one correction to make. We sent you a letter dated October28th, and then we sent a correction on November4th. We apologize for our answer to section 11 where it may have been construed we were speaking of specialists, when we were actually speaking of people with higher qualifications. In fact there is no registered specialist in Trinidad and Tobago, and that was a question you specifically asked and we have answered.

Mr. Chairman: We will get into it further.

Prof. Seemungal: We hope that at the end of this, if you agree with us that there is a need for modification of the Act, that the Parliament would be able to assist us with that when the time comes. Thank you, Sir.

Mr. Chairman: Ministry of Health, Mr. Madray.

Mr. Madray: Chair and members, good morning. I wish to express my thanks for granting us the opportunity to appear before this Committee. The role of the Ministry of Health is policy formulation, planning, regulation and the monitoring of the health sector of Trinidad and Tobago and, therefore, the regularization of medical doctors in the health system is a key facet for us to ensure and preserve the high level of quality care throughout the sector. So again thank you for this opportunity of appearing before you.

Mr. Chairman: Thank you. NIPDEC.

Mr. Benjamin: Good morning again, Committee. Thank you for the opportunity to be here. We are honoured to be here to share the information that you might want from us.

NIPDEC is a 40-year-old provider of outsource management services to Government, and while it is mainly a construction project management entity for most of its life, in this case we are providing services to the Ministry of Health to manage the operations of pharmaceutical procurement, storage and distribution. That is our role at the wholesale level for the health sector in Trinidad and Tobago. We hope to share any information that might be of interest to you in our operations in pharmaceuticals.

Mr. Chairman: Thank you very much. Ladies and gentlemen, I will now open the floor for members to ask questions during the course of this enquiry. The first question will come from Vice-Chair, Miss Ramona Ramdial.

Miss Ramdial: Good morning again all. To the President, Mr. Seemungal, you made a statement just before we officially started, about not having any registered specialist. But how is it out there in the public domain there are widely advertised specialists in Trinidad and Tobago? How come that is allowed when you have no official registry of specialists in Trinidad and Tobago?

Mr. Madray: I think what you are referring to is people—when they have the higher qualifications, they are usually recognized by their peers as specialists and therefore considered as such. But the Medical Board Act, I think 2008 or

2007, specifically said that there should be a specialist register. However, there has been a lot of difficulty in coming up with the criteria for the register, and it was only when the regulations were passed in 2014 that we had what was necessary to do so. We have now come up with a policy to implement those regulations, and the policy is now with the Ministry. We are hopefully fine-tuning a bit of it, and we expect that it should be out very shortly on our website.

Mr. Chairman: So what you are saying, let me get it clear, is the fact that you may have somebody who has higher qualifications, the fact that you have higher qualifications does that in itself make you a specialist?

Prof. Seemungal: Not according to the Medical Board Act right now because we have not proclaimed a specialist register.

Mr. Chairman: So according to the Medical Board of Trinidad and Tobago, right now we really have no specialists?

Prof. Seemungal: Yes, that is right.

Mr. Chairman: Legally, nobody can considered himself a specialist per se?

Prof. Seemungal: Yes, but we have several people who are registered as specialists in different jurisdictions such as the UK or North America, and they would be registered on those registering bodies as specialists, but not here in Trinidad and Tobago.

Mrs. Baptiste-Primus: Thank you kindly, Chairman. Through you, Mr. Chairman, to the President. Just as an addendum to my colleague's question, we are all aware, it is a fact, that a number of doctors have been high profiled as specialists. If there is no registered specialist in Trinidad and Tobago, what has the board done to prevent the proliferation of that kind of projection which comes with it certain sums, certain fees that are charged for being specialists? What has the board done about that?

Prof. Seemungal: As far as I know, I can say that since—I have been there as President since 2015, what we have been working on is to get the policy out so that we can have a specialist register. To the best of my knowledge there is no regulation with regard to fees that doctors charge.

Mr. Chairman: So really and truly, Prof Seemungal, there is nothing to stop anybody from holding themselves out as a specialist and charging fees as a specialist?

Prof. Seemungal: All I can tell you is since 2015 the Council has been working to get out a policy.

Mr. Chairman: I understand that, but I am saying at this point in time there is nothing to prevent anybody from holding themselves out as a specialist and charging specialist fees?

Prof. Seemungal: Well I am not aware of anything. Yes, you are right.

Mr. Chairman: And this has been going on from time immemorial.

Prof. Seemungal: From before 1960.

Mr. Chairman: The regulations to be proclaimed you said it is at the Ministry of the Attorney General?

Prof. Seemungal: The regulations have been proclaimed in 2014, but the policy to effect the regulations has been

formulated by the Council. We presented them to our colleagues on the board and it is now with the Ministry of Health.

Mrs. Baptiste-Primus: Mr. Chairman, I will like to ask Dr. Akenath Misir, the Chief Medical Officer—because this is a very important mechanism. We know in Trinidad and Tobago and the population there are high levels of concerns. Where exactly is this draft policy at the level of the Ministry of Health?

10. 30 a.m.

Dr. Misir: Thank you, member, for the question. It is an iterative process, as you would appreciate, between the Medical Council and the Medical Board and the Ministry of Health. Because at the end of the day it has to be proclaimed by hon. Minister before we can actually effect it into law. So that that is what—there are one or two areas that we are undergoing to, you know, review, discussion, consensus with the members. Now remember the Medical Board comprises of all the practitioners in the field, so that we have to have consensus with them before we can agree on anything going forward.

Now, you would appreciate that it took us from 2007 to 2014 to get the regulations proclaimed and gazetted and so on, and now to effect that we have to have some kind of a policy because as you correctly said, persons are currently holding out themselves to be specialists in their particular field. So we have to be, you know, very careful in terms of grandfathering people and other ways of getting it to tidy up the whole exercise. So, I agree with you and I share your concern, but it is something that we are actively pursuing and I am hoping that, you know, within a reasonable time frame we would actually have a specialists' register that somebody could go on the website and they could ascertain from there what a doctor is, a speciality, in what field and that sort of thing.

Miss Ramdial: In addition to that, and this again is to Mr. Seemungal, the president. So in addition to having unregistered specialists practising in Trinidad and Tobago, we also have a situation where doctors can practise without renewing their licences. Do you care to comment on that also?

Prof. Seemungal: Thank you for the question, Vice-Chairman. That is a very sad state of affairs and the problem with that is the Medical Board Act. In fact, if you look at—you also asked what changes we wanted to make and we have sent those to you. What has happened is, there is a rigorous procedure before you become registered. That is, you have to supply a certificate of good character, although we have delineated all of those to you. But if once you are registered you do not pay your fees, we do not have a procedure to erase you because of that. That is the problem. In fact, you all also asked what we consider as best practice, and we referred to the General Medical Council of the UK. They actually do not have a registration fee. They ask for the annual retention fee. So that you know if you do not pay it, your name can be removed within a period of time from the register. So we do not have that legal capability. Thank you.

Mr. Chairman: But at present, does the Medical Board of Trinidad and Tobago carry an insurance coverage for all

its members against malpractice?

Mr. Seemungal: No. The board does not.

Mr. Chairman: Is it something you all are considering?

Mr. Seemungal: No. It is not under consideration because doctors have independent malpractice insurance with the Medical Protection Society.

Mr. Chairman: All doctors?

Mr. Seemungal: All doctors—well I would not know if it is all doctors, but doctors should have it in the private system. And in the public system because the Medical Protection Society would not cover them, I believe that there is another—there is—well, the Ministry would have to help me here, but I think there is vicarious liability coverage with the Attorney General.

Mr. Chairman: Dr. Misir, what I would like to ask you is that, in terms of the private medical facilities that operate in Trinidad and Tobago, is the Ministry—is there a mandatory requirement that they carry medical coverage, provision of medical services in their entities?

Dr. Misir: Thanks, Chair. Under the Private Hospitals Act, first, when you are applying for a licence to open and operate a private health facility, again we have guidelines and within the Act is stated, depending on the size and the services that you are going to offer to the public, there is a requirement there to provide the personnel, the skilled personnel to cover your facility. And, of course, every year we do an inspection because every year you have to apply for renewal of your licence. Our staff from the Ministry would visit and they would inspect and make a recommendation whether you could continue to be licensed. So within the application you would have to describe the personnel that you would have, the skills, the number of beds and that sort of thing, that kind of detail and that is what will help us to decide whether a licence will be granted.

Mr. Chairman: Well a licence, but you are saying insurance, I am speaking about the insurance. So the private entity will have the insurance to cover the persons, all medical persons, all medical staff, professional and otherwise working with them or not?

Dr. Misir: Well, for the licensing, that is not a requirement that they must show evidence that they have insurance for the persons. But I know through the Trinidad and Tobago Medical Association and other bodies and so on, most practitioners would have some kind of insurance. And in the public system, as we were discussing earlier, through vicarious liability and the Attorney General's Office and so on, that is the coverage that we will provide for our medical practitioners in the public health system.

Mr. Chairman: But you realize that in Trinidad and Tobago we do have a serious problem with medical malpractice on the rise. You appreciate that?

Dr. Misir: Yes.

Mr. Chairman: And a lot of it is not coming only from the public arena, it is also coming from the private enterprise. So, do you not think that, at this point in time, it is important that the Ministry takes a look at protecting the interest of the unassuming public that is going in to receive these services and may be exposed to malpractice without any measure of compensation thereafter?

Dr. Misir: And I totally agree with you, Chair. That, yes, that is what, in terms of the current legislation and in moving forward, I agree with you that we need to look at that in terms of—once we make this a requirement for granting a licence, of course, then we could police it down the road through regulations and enforcement and so on, but I agree with you.

Mr. Chairman: Mr. Solomon.

Mr. Solomon: Just following through the Chair, following on from that. So what protection does a person, a patient who has suffered some medical negligence without being able to afford necessarily lawyers and what not? What sort of protection do those persons have?

Dr. Misir: Well, currently the practice is that they would make a complaint to the Medical Board and the Medical Council. I mean, that is one avenue there. You can make a complaint against a practitioner. Right?—and then we will take it from there in terms of our investigative procedures and so on.

Mr. Solomon: What sort of compensation and what is the procedure and how often does that actually successfully happen?

Dr. Misir: Well, again, that is the ambit of our courts, our legal system. In terms of compensation. And I mean, of course, you have to go to court, you have to have, you know, the procedure, you have to have due process and so on before that is arrived at.

Mr. Solomon: Go ahead, Chair.

Mr. Chairman: Yeah. Dr. Misir, I do not mean to put you on the "hot seat", eh. But what I am seeing from what you all submitted here, in terms of—sorry, the Medical Board and the Medical Council, in terms of proffering charges or bringing anybody to successful litigation, in 15 years you all had one person that was brought before you. I mean, this is woefully—either we have incredibly good doctors in Trinidad and Tobago or, I mean, the Medical Board, the Medical Council is not doing what they are supposed to be doing. Because, I mean, this cannot be.

Almost every morning without failure you are hearing complaints about medical malpractice here, there and who dying, who crippled and "all kinda ah thing". I am a victim of that myself. Right? And you tell me just one person in 15 years. That cannot be. Something has to be wrong. And the members of the Medical Council themselves, is it because we live in a small community and it is who guarding the guards, who policing the police? Is that a case of just, in this instance here, the Medical Board, the Medical Council why we have not had any successful litigation in terms of the number of instances of allegations of malpractice that has been taking place in the country?

Prof. Seemungal: Is that addressed to me, Sir?

Mr. Chairman: Yes.

Prof. Seemungal: Okay. The Medical Board Act, 1960 does not provide for the council to adjudicate on matters of negligence or malpractice. We adjudicate on matters of infamous or disgraceful conduct. So a matter of malpractice or negligence has to go to the courts.

Mr. Chairman: But in terms of disgraceful conduct or—

Prof. Seemungal: And that is precisely defined under our—let me see. If you look at the Act there are a series of what is defined as infamous or disgraceful conduct. Section 24 paragraph two—

Mr. Chairman: Yeah.

Prof. Seemungal:—it says exactly what all of these things are. So once they fall within that, they can be dealt with and there are levels of discipline, one is:

> "censure or reprimand…
>
> suspend the…practitioner concerned for a period not exceeding two years; or"

—erasure. And those are the three penalties that we have at our disposal.

Mr. Chairman: And how many times has that been actually activated or—

Prof. Seemungal: So with regard to erasure, it has been once and with regard to the others, I do not think I can—I think you asked us that and the answer may be there, if you asked us, but I cannot tell you that off the top of my head and we would be happy to provide that for you, if you wish.

Mr. Chairman: One person was suspended for six months or something so?

Dr. Misir: Okay. We had one erasure.

Mr. Chairman: One erasure.

Prof. Seemungal: One erasure. Yes.

Mr. Chairman: Okay.

Mr. De Freitas: Chair—

Mr. Chairman: Yes, please. Go ahead.

Mr. De Freitas: In your submission you indicated that there is no mention of a malpractice register in the Medical Board Act, 1960. Now in my opinion and to have a malpractice register you would need to, as the Chair indicated, actually investigate instances of malpractice. But you just indicated that malpractice does not even really appear in the Act itself. So my question is: in terms of the malpractice register, is there amendment forthcoming with regard to the Act to put that in or to fix that situation and implement or input "malpractice", that word, and what it means into the Act so that we can start to deal with that to the betterment of the people of Trinidad and Tobago?

Prof. Seemungal: I think you might want to ask the legal counsel that one. If I recall correctly, it was not in the draft

that we sent to you all, but it is something that we certainly can consider.

Mr. De. Freitas: Perhaps the legal counsel.

Mrs. Kowlessar-Tagaille: I must apologize. Thank you for the question, but I am unable to confirm whether the Medical Board would have ever made any submissions—the council, the Medical Board would have ever made any submissions from a policy change perspective to include that specifically as an amendment to the Act at this time.

Prof. Seemungal: I do not think we have. What they are asking is: what would it take to get it done?

Mrs. Kowlessar-Tagaille: Right. So, once that position, the policy position that comes from the council, it needs to be submitted to the Ministry of Health. The Minister of Health is responsible for the approval of any rules and regulations and, of course, amendments to the legislation that may come forward. So he would have to review it, consider it and once in agreement, then the necessary steps can be taken to effect the change to the legislation.

Mr. Chairman: So it has not been—by any council? Yes?

Mr. Ogilvie: A proposal has to come—

Mrs. Baptiste-Primus: Thank you, Chairman. Mr. President, in your council's submission the Medical Board submission dated 20th October signed by your secretary—and I am just picking up the thread. In your submission your board stated:

> A malpractice register is not provided for within the Medical Board Act of 1960, and such must be enacted in law before it can be implemented.

If that failure has been identified, why no recommendation, specific recommendations from the board for the amendment of the legislation to make such a provision? Because it has to come from you all to the Ministry of Health. And I just heard a discourse there where you "pass the ball" to the state council who indicated that they are prepared to do it once it comes from you all. So, I know your appointment as president of the board is of recent vintage, December2015. That does not relinquish the responsibility of the board to look after the interest of the citizens of Trinidad and Tobago.

And secondly, the issue on mandatory registration in Trinidad and Tobago where a medical doctor can practice without renewing a licence. That is totally unacceptable and the board should move post-haste to ensure such mechanisms are put in place for the protection of the citizens of Trinidad and Tobago.

And last year, Mr. Chair, the issue of the registration of doctors being accessible to members of the public in order to ensure transparency, I read where you all charge, although it is a peppercorn fee of a dollar, it should not be. That information should be opened to all and sundry. It should be on the Ministry of Health's website, your website. Nobody should have to pay for such information in the event that they need it. So these are some low-hanging fruits that the board can attend to with a sense of urgency. Because I get the impression, Mr. Chairman, and I just want to refer to your submission, again, Mr. President, Prof. Seemungal, on page 6. It is reflective of a level of, how do you

call it, lethargy in the board because hear what it says with regard to:

> "…the practices and procedures adhered to…in relation to disciplinary proceedings involving medical doctors;"

We are told by you all, upon receipt of the response from the board member, well you will ensure if someone makes a complaint that the principles of natural justice, the doctor is given all the information. Upon receipt of that information hear what happens, by your record to us:

> Upon receipt of response from board member, counsel will then make a determination at a regular monthly meeting.

There should be a specific procedure—within 14 days, that is a good start. The doctor is given all information so he or she can make a response, but you all have to go further, that:

> Upon receipt of the doctor's response, the Medical Board shall sit and deliberate within sevendays.

That is an error that you all need to pay attention to, a specific procedure in terms of ensuring that the issue is carried to its logical conclusion. Thanks, Mr. Chairman.

Mr. Chairman: Professor.

Prof. Seemungal: I am making a note of it, Sir. Thank you, Mrs. Baptiste.

Mrs. Baptiste-Primus: Primus. My husband would not be at all happy—

Prof. Seemungal: Sorry.

Mrs. Baptiste-Primus:—if you left his name out.

Prof. Seemungal: Sorry. I know you from the union from years ago. [*Laughter*]

Mrs. Baptiste-Primus: I know.

Prof. Seemungal: I think what you are saying is logical and it is obvious. The reason that it—and the way that the Medical Council is made up, you have people who are full-time practitioners. So every time that they come to council meetings their income is impaired, that is the practicality. And I have been thinking about that and I believe the only way around it is to have full-time members on the council or at least a segment of the council as full-time, and that would mean changing our hiring practices and, of course, changing the Act because of the way that people are appointed. But the only way you are going to get—in fact, having that meeting once a month, it starts around 4 o'clock and usually goes until 10,00 after a full day's work for most people. And I did ask for us to move it during the day, but of course, it interferes with people's income potential and so on. So, as I say, it is sensible and I think the only way around it is for us to reconfigure how the board is composed or comprised.

Miss Ramdial: Okay. Prof. Seemungal, the stakeholders within the medical fraternity for many years they have been asking for continuous medical education especially the TTMA. Can you give us an update with respect to how the Medical Board intends to treat with this? And of course, if not, also a response from the Ministry?

Prof. Seemungal: Okay. So the board—okay. So this is again before my time, but what I understand in preparing for this meeting is that the board has already agreed in principle to continuing medical education credits that you must have which is why the TTMA went ahead and did it. But the history is somehow, I think, when it went to the Ministry there were some problems so it was sent back to the council. So, we are expecting to take that in early next year. This current council would take that in early next year to the Ministry.

The thing is, the Medical Board according to the current Act cannot enforce CMEs simply because we have no way within the Act to do it. So the Act needs to be modified so that you would need to provide your CMEs and then we will continue your registration. So at the point at which you come for your annual retention, to pay your annual retention fee, as it were, is when we need to look at it and see—otherwise we have no handle on it. So it is a very good idea. And what we thought we would start with is 10 hours at first, and over the three years to increase to a maximum of 18 or 20 hours for each practitioner and more for specialists.

Mr. Chairman: In order to maintain your registry?

Prof. Seemungal: Yes. But the law has to be changed to allow us to do that.

Mr. Chairman: Right. Of the 261, I am looking at the Medical Board's submission on page three, is it? The number of persons to practice medicine in Trinidad and Tobago for the past 10 years. In the year 2015 you have total fully admitted medical practitioners would 261. I do not know if you have the figures. Well we are still in 2016. Right? But of the 261, there seems to be a cry, an outcry in Trinidad and Tobago for lack of specialists in a number of areas. Okay? Is that so?

Prof. Seemungal: Yes. That is so.

Mr. Chairman: Yes. Now, what if anything, the Medical Council is doing to address that in terms of policy recommendation, as such, to the Ministry?

Prof. Seemungal: All right. So, what has happened in Trinidad and Tobago is that there was a need for doctors, historically. So there are now a lot of doctors, but they are not at the subspecialist level. So, you have specialists, but then you have subspecialists.

Mr. Chairman: Right.

Prof. Seemungal: So, for example, you have a specialist internist, but you have a subspecialist in cardiology or gastroenterology. So that is where the need arises. But the Medical Board has no remit in that. That is a question of how you give your scholarships and so on to let people go away or you have training programmes that are stimulated within the in University of the West Indies. So we do not have a specific remit in that.

Mr. Chairman: Yeah. But I am asking, I understand that from the Act. But I am asking, being proactive, have you all made any suggestions, policies to the Ministry in addressing that as a professional body?

Prof. Seemungal: Okay. I can say for the time that I have been there, no. I am not aware of any, and I do not know

if historically any were made.

Mr. Chairman: So, of course, the question goes to Mr. Misir, Dr. Misir, now at this point in time. How are you all addressing this?

Dr. Misir: Okay. So this challenge, and thanks for the question, Chair, I think it is timely and it is appropriate because—just some background information in terms of scholarships for training, now that has changed, Ministries and so. But over the years we have been engaging the scholarship division. It used to be under the Ministry of Public Administration, now I think it is under the Ministry of Education. That has been transferred to Ministry of Education. So currently we are engaging the Ministry of Education and we have identified a number of areas, based on our needs assessment for the country, these are the specialty areas that they should be offering some kind of a scholarship to allow our nationals to pursue training whether it is locally at the University of the West Indies, for example, or whether it has to go to one of the metropolitan countries. But right now that is engaging us and we have identified a number of speciality areas that we would probably be offering scholarships for our doctors to go and do postgraduate training in foreign countries.

Mr. Chairman: And is this something for near future, the immediate future?

Dr. Misir: No. No. This is something for the immediate future.

Mr. Chairman: Right. Immediate future.

Dr. Misir: Because of the change in Ministries and so, there was a little, like a little period where it has lapse, but we are actively pursuing the Ministry of Education now in terms of allocation of the requisite funding to allow our nationals to pursue this kind of postgraduate qualifications to come back and serve our country. Because as you would appreciate, over the years a number persons would have gone and they would have been grabbed up, you know the so called "brain drain", in other countries and they have not returned, but we are trying to tighten up in terms of the bonding arrangement and so on, so that when we do fund the training for our nationals, they have to come back here and serve our people.

Mr. Chairman: I am glad that you raised that because the next question I was going to ask is that, I am sure you all are aware that there are number of locals that go abroad on scholarship or otherwise and acquire very critical skills in medicine, heart and neurology and you name it. Right? But however, when they seek to come back and get back into the practice of their speciality in Trinidad, there seems to be a blockage, there seems to be a problem. I have heard this for a number of years. There seems to be people somewhere, some cabal, people talk about a monopoly, there is a close off that they cannot come back. I have heard about heart specialists.

I remember there was a guy a couple years ago before I was paralyzed, came to me, went to school with me, he is a top heart specialist in the United States and he came back here on several occasions to get back in, and he said he just could not, and in frustration he left and he went back. There is another—I mean, I could go on. There are a

number of persons who have come to me over the period of time, before I became a Senator, and mentioned that to me. So there seems to be a real issue with that. Are you aware of it?

Prof. Seemungal: Yes. I am aware of it. I do not know, I cannot pinpoint it, but I have had same complaints made to me over several years. I had a colleague who extremely well specialized in nephrology and she said that she left here in frustration. She felt she was not given the recognition or she was not allowed to participate at her level in various things and she is now at the Cleveland Clinic.

Mr. Chairman: Dr. Misir, what is the problem? Is the Ministry aware of that?

Dr. Misir: Yes. Yes. Chair, we are aware of that, but like I said before, you know, we are trying to tighten the arrangements. So what we are trying to do now is that we are trying to—like for example, as Prof. Seemungal mentioned, if we are going to expend, you know, taxpayer's dollars to fund a nephrologist to be trained. And what we are trying to do now is to ensure that they are bonded sufficiently that if they do not return, they would have to pay back the cost of their training.

And secondly, we are trying now—remember the Ministry of Health through the RHAs, the RHAs are really the delivery arm of the Ministry of Health, and we are saying to them that they must create in their establishment the requisite positions so that when these persons return, then they would, you know, be able to quickly assume appointment.

Mr. Chairman: But we are on a slightly—this is going forward which I appreciate, but I am speaking about those who are qualified whether or not they went on scholarships or not. They are locals who went abroad, acquired skills and now coming back. I practised law internationally, but when I was ready to come back here, nobody stopped me. I came back and got back into practice. That does not seem to be the problem with those who are faring in the medical field. They are being frustrated coming back. What is the issue? What is causing that? And why they are not able to enter into practice? What is the issue?

Dr. Misir: I mean, I honestly cannot give you an answer to that. All I can tell you is whatever efforts we are making to deal with these scenarios. Because as you said, I mean, I do not want to use like cabals and so on because I am not aware of that.

Mr. Chairman: Yeah. Well there seems to be some—

Dr. Misir: Okay. Yeah. What we are trying to do, Chair, sorry about that interruption, is that we are trying to match the training with the provision of the positions in the establishment for when they return so that there is a smooth transition.

Mr. Chairman: Professor, last question before that. Prof. Seemungal, there is also the issue of young doctors being registrars or so trying to access higher and specialized training. There always seems to be a difficulty to get into these specialized training. Why is that so?

Prof. Seemungal: Okay. Two reasons, the first is—

Mr. Chairman: So first of all, you agree with me?

Prof. Seemungal: Yes. I agree with you. Yes. Yes. The first is that the training away is very, very costly—okay?—and you have to competitively apply to get into a training programme away. If that is not allowed because the programme is full, then you have to come with full fees which is, of course, a very expensive thing for the Government here to pay for you. So that is one blockage.

The second one is, the lack of enough local training programmes. So, you know, that is something that can be fixed, but it requires, again, a certain degree of effort on the part of the profession and the Ministry of Health to come up with the necessary programmes because the programmes are all taught in the public health system.

Mr. Chairman: But how transparent and objective is the criteria to access this level of training, specialized training? How objective it is?

Prof. Seemungal: I am not clear on that. Okay. If you are applying to the University of the West Indies, you have to apply in open competition and the department concerned has a meeting and they look at the criteria required for which they would have had on their website.

Mr. Chairman: There is a—

Prof. Seemungal: To get into it.

Mr. Chairman:—to the evaluation?

Prof. Seemungal: Yes. Sorry?

Mr. Chairman: There is an objective evaluation process?

Prof. Seemungal: Yes. Yes. Yes. But the number of speciality programmes offered by the university is limited at present. So, for example, if you wanted to do a speciality in rehabilitation medicine which we need a lot of people in that, you have to go away for it, or in palliative care, you have to go away for that. And that requires you to apply in open competition, say, in the United States. In England—a lot of our specialists previously went to England, and that is another reason for the bottleneck that you have observed. But the English channels were closed off when England became a full member of the EU and they could not take West Indian graduates because of that.

11.00 a.m.

Mr. Madray: May I just add to that. Of course the problem is clearly a multifaceted problem that will have different types of responses. One of those responses is to work with the University of the West Indies to see whether we can introduce certain types of specialized training which, presumably, would be less costly than having to send persons abroad. So, we are in fact actively engaging discussions with the university on such programmes. Of course, introducing a specialized programme does require quite a bit of effort on the part of the Ministry and the university, and the logistics involved, but there are some programmes that are in train in terms of active discussion.

Secondly, with respect to processes for accessing specialized training as Dr. Misir would have mentioned, through the Ministry of Education there is the scholarship programme and there is a process involve for determining which applicants would be eligible for accessing those programmes. Again, we will be having discussions with the Ministry of Education shortly to see whether we can fine-tune and improve the focus on those types of opportunities.

Mr. Chairman: Thank you very much, encouraging.

Miss Ramdial: Thank you. From our submissions received, the Trinidad and Tobago Registered Nurses Association has identified that there is a shortage of medical doctors in the public health facilities. I know that Prof. Seemungal spoke about having doctors in Trinidad and Tobago, and we are seeing that there is a negative impact on the delivery of health care at the public facilities. We have a shortage of registrars, house officers, consultants, and sometimes the medical interns themselves are not properly supervised by the senior officers because of the absence or the shortages that exist within the public health system. What is the Medical Board and the Ministry of Health doing to alleviate the situation and to assist the public health care system?

Prof. Seemungal: Okay, so we have no remit in that one I am afraid. If I were permitted to state an opinion though, I do not think that there is any shortage—to the best of my knowledge, again the CMO could—of junior doctors. The problem is at specialist and subspecialist level, and that is where I think it affects care. But, I will let the Ministry answer on that one.

Mr. Madray: Well, I would defer it to the CMO shortly, but I will just endorse what is being said there. The country has invested heavily in the training of doctors over the years, and we have reached the point where we do have a strong supply of doctors at the entry level—that is what you would call the house doctors—and we have people entrained in the system who will be coming out in due course. So, the focus really does have to be now shifted to the higher levels, the specialized levels. But, I will just ask Dr. Misir if he can add to what I have just said.

Dr. Misir: Thank you PS, and thank you Chair. Just, maybe, to put some perspective on this entire scenario. Now, let me begin by letting you all know that right now we are actively engaging, in fact we have a consultant through IDB funding and so on. We are developing what we call a 10-year manpower plan for the health sector based on our demographics, based on what we expect. We are an ageing society and so on, we are looking at what we think will be our needs for medical professionals, and other allied health workers for the next 10 years. Once that is agreed upon then we will be—again, we are engaging the Ministry of Education in terms of offering scholarships for training in the areas that we have identified where we would need specialists. Like Prof. Seemungal mentioned they are about rehabilitation because we know we are seeing more and more patients with strokes and so on, that we would need a lot of rehabilitation services to support these, so that they would have a good quality of life.

Now, as mentioned before, we have right now at the entry level or the house officer level as we say, we have quite a few doctors. At the specialty level is where we have a deficiency, we do not have enough, and that is what we

are trying now through a number of avenues. First of all, and it was mentioned in the response, we are still recruiting doctors from other jurisdictions to fill these vacancies. We are trying to offer training programmes and scholarships to help fill these vacancies, and of course returning nationals that was mentioned, we are also pursuing that. So, a number of efforts, a number of things are being done to address this area of deficiency or shortage, and it all depends on resources, it depends on funding. So, it is a number of things as PS said, it is multifaceted and multifactorial, and it is not something that could be fixed very easily, but we are trying to see how we can address these so that at the end of the day our citizens will get the quality care that they deserve.

Mr. De Freitas: All right, so I am starting to see a bigger picture forming here with regard to all the questions that have been answered so far. So what I am hearing is that we have sufficient house doctors, and I guess as years passed and they continued their education, which is not mandatory here, as you indicated, they become specialist. And I want to assume that as they become specialist I am seeing another part of the submission that came in where the Ministry allows doctors to have a private practice along with their public service in the hospitals. So I am going to assume that as they become specialists they move more towards their private practice where they can charge a lot more money, and then the hours in the public service comes down.

So, I want to go out and say that you do not have a shortage of specialists, what you have is a shortage of hours of the specialists in the public service, and that is where you are having a problem. If it is you were to get rid of this provision where they are allowed to work both areas you may find that you have enough doctors to fill that position, because as you indicated there is no acknowledgement of specialist in the country. There is no register. Anybody could call themself a specialist and charge. So, we see that is what is going on in the private sector where we have so many specialists, then you do not have a shortage. What you have is a shortage of doctors working in the public service because they are busy working in the private sector. What recommendations can you make to solve that?

Dr. Misir: I will defer to the Permanent Secretary.

Mr. Chairman: Very good question.

Mr. Madray: I hope my answer is a very good answer. So, the Prime Minister in November 2015 established a committee to look at issues of the provision of health care by the RHAs, and the second aspect of the remit of that committee was to address the issues that you have raised here, that is the practice of having doctors in the public health system but at the same time allowing the private sector work. That report was delivered by the Minister of Health to Parliament on November 9th this year, and therefore it is now in the public domain as of the last two days. The issue that you have raised, as I mentioned, was part of the remit of the committee, but the committee was unable to provide comprehensive advice and a recommendation regarding the path forward, and therefore that matter is still the subject of review.

Mr. Chairman: Wow, wow.

Prof. Seemungal: Can I just make a personal comment here. I am not speaking as president of the Medical Board, but as a practitioner. I think Mrs. Baptiste-Primus would recall the 1976 agreement with the PSA at the time, because doctors were part of the PSA at that time in which they recognized that the Ministry could not afford to pay specialists to come into the public system, but what they would do, they would give their standard salary whatever range it was and allow people—consultants—indefinite private practice, but the trade-off was that you should manage your unit and you should be available if there were any emergencies. Subsequent to that when the doctors went into a different union the salary of doctors did move up, but if I could draw a parallel with the UK, the starting salary for a consultant in the UK is £80,000 per year, but you are forbidden from private practice, and once you sign that, if you go into private practice you will be held accountable.

So, the question is one of funding, I think, and if the country is prepared to pay for that. What we have is a mixed system now, a little bit of this and a little bit that, and as Mr. De Freitas pointed out, he does not think that it is working, and I think that that is the case. But we have to decide how we are going to do that, or the alternative could be to pay for specialist, probably say for half the day and the registrars do the rest, and people are then accountable and maybe have to sign, or whatever. However you come up with it, some sort of formula so that they give the hours that you wish.

Mr. Chairman: But do you know—I am familiar with institutions in Israel. In Israel public health sector offers premium medical service compared to the private sector. You can get the most complicated, the most efficient procedures, whatever service required medically in an Israeli public hospital, from the Prime Minister, the generals, and everybody go there, as opposed to surviving at a private enterprise. What I was told when I was there, that private hospitals struggle to make it in Israel. The public hospitals are the premium hospitals.

What would it take for Trinidad and Tobago to reach there? We have a proliferation of private hospitals here, and what I understand, when things go wrong—you go to the private hospitals, you pay a lot of money, and when things go wrong they pack you to the general hospital, either to go and die or to live out the rest of your broken self. What would it take to reverse that and have what goes on in Israel in Trinidad and Tobago, where we can have the best consultants, they best everything in our service? The best equipment, everything in our public hospitals? Is it a change of policy? Is it the lack of will?

Prof. Seemungal: That is not something the medical board could answer, but as a practitioner—

Mr. Chairman: No, I know, anyone of you in here.

Dr. Misir: Again, thanks for the question, and again it is a very critical question at this point in our history as a country, Chair, and I am happy that you raised it and I am going to give you my view here. And my view here is to solve these problems you have to have a single payer. Once you have one person underwriting the cost of medical

services, problem solve. And until as a country and as a people we decide that we will fully institute a national health insurance system that is adequately funded then this problem will be pre-empted. And until that time that we make a decision, a conscious decision that this is what we want—we want to be able to provide, just as in Israel, and a number of other countries, they make that decision. The Canada Health Care Act speaks to that, because Canadians want health care. Health care is a priority for them. And until we do not make that kind of decision as a people and as a country then we will continue to grapple with this kind of problem. The problem here is a fundamental policy decision that you quite correctly alluded to, but who is going to take that decision on behalf of the people of Trinidad and Tobago. That is where the solution lies.

Mr. Chairman: Thank you for that pointed answer.

Mrs. Baptiste-Primus: Chairman, I want to point out, and I just want to refer to earlier expression of Prof. Seemungal. Indeed, at one point in time the organization I belonged to was responsible for negotiating. That was a negotiated term and condition, specialists being able to engage in private practice. At that point in time it was a relevant action, but over the years we have far outgrown such a situation, and therefore the medical board, the medical association, the Ministry of Health have a responsibility to come together, identify the weak areas and to deal with it. But you know what, the bottom line is ladies and gentlemen, you all keep passing the buck. You all do not want to make a recommendation, because it is impacting the bottom line, the dollar line, and as a society we really have to pull ourselves back from the edge. The citizenry of Trinidad and Tobago require nothing less, and we all sit here, and we all are aware that private practice has impacted to a very large extent on the delivery of proper health care.

I have always boasted over the years, we have the best doctors in the public health system. The best doctors. But, are we getting value for money? And I think that is the issue that the medical board, you have a grave responsibility to sit and engage in that kind of dispassionate dialogue, and identify what it takes to get us out from where we are. Because we still have—people meet me all the time and complain, I went to this hospital because of this problem, but I was told we do not have X or we do not have Y, however you can visit me in private hospital X or Y where we can do it for $35,000, $65,000. Ladies and gentlemen we still have that existing today. Those are some of the issues and we cannot run away from it because it means more and more of our people are dying when they ought not to die.

Miss Ramdial: And that is why, continuing from my colleague here, I would like to suggest to the Ministry of Health that you probably need to look at a proper remuneration package for these doctors we have working in public health system. In addition to that, there is a little bit of confusion with the foreign doctors also. If you are telling me that there are no shortages of house doctors in the public system, why is there a need to bring in these foreign doctors? Is it that they are at the specialist or consultant levels? And if it is you are saying that there are no positions for consultants in the public health system, how are these foreign doctors plugging the gaps that we have here in our health sector?

Prof. Seemungal, you care to?

Prof. Seemungal: So, the Medical Board just gives them temporary registration when the Ministry applies to us.

Mr. Madray: I will respond to the first aspect of the question by again pointing back to the health committee which I mentioned has deliberated for a year on the subject of the private practice issue. But, again, it has gone and it is still there for review, so we do hope that through those considerations some path forward can be recommended. With respect to the Ministry's employment of foreign doctors, I am advised that those doctors are doctors with experience, so they are not coming in really at the entry level. It is not any house doctors.

Miss Ramdial: So, they are not house doctors, so are they specialists or consultants? How do you classify them?

Mr. Madray: I am being advised, yes, that they are senior doctors, I understand, at registrar level and specialist level.

Miss Ramdial: So then why are there still shortages in our public health system of these said registrars, and consultants, and specialists? Is it that we are not importing the amount of foreign doctors? Or, is it that we are not on the trend of training our own home-grown doctors here to these positions? I know you say it is a dynamic situation and all of that, but we need put the priority on training our own home-grown doctors to these senior levels so we can curb the importation of foreign doctors. Do you not agree?

Mr. Madray: Yes, of course. Of course, it is a very good question. As I mentioned, we do have to take a—there are multiple strategies that have to be implemented. One, again, is the strategy of the foreign training through the scholarship programme. And secondly, the results of that is not going to be overnight. So, we do have to have the secondary strategy of employing the foreign experienced doctors whilst we do address those other options. And it also depends on the pool of people that in fact are interested in so undertaking specialized training.

Miss Ramdial: Just one little—okay.

Mr. Chairman: All right, continue.

Miss Ramdial: Just one little point on that. In recent times also because of the economic situation that we are in, we have learned that GATE has also been cut for the postgrad training. Correct me if I am wrong. GATE has been cut with respect to doctors seeking to further postgrad studies, so now the onus falls directly on the Ministry of Health with respect to the postgrad scholarships. How is it that you are working the situation out, because we have many doctors, junior doctors who have applied to study postgrad studies, that is, GATE has been cut, how are we dealing with that situation?

Mr. Madray: Well, we would prefer to work with the Ministry of Education through a single process for the award of scholarships. So, this is why we will be continuing our relationship and collaboration with them for that scholarship programme. They have a list form us of the specialized areas of need, but it is necessary to continue to have ongoing collaboration to make sure that we get the kinds of results that we need to.

Mr. Chairman: Again, back to the Ministry of Health. In keeping with the discussion of shortage and supplies, and

supply and demand and so forth, unfortunately one of the areas that seems to be in dire need in Trinidad and Tobago is our Forensic Science Centre in terms of forensic pathologist. I read Dr. Des Vignes' submission to us, and again it kept for me to clarify some of the concerns dealing with specialists, and subspecialists, and so forth, right. Because, according to what was said this morning, there are no specialists list in Trinidad and Tobago, and therefore anybody could hold them self out as a specialist. There was some clarification, I think, made by another doctor, I think the medical board was explaining that you can carry out specialist functions without considering yourself as specialized, you are trained as a MBBS, is it? As a medical doctor to do a number of things, you could carry out brain surgery, you could do pathology, once you do not hold yourself out to be a neurosurgeon or a pathologist, you would not be misrepresenting to the public, am I correct?

Dr. Misir: Yes, that is correct.

Mr. Chairman: Right. Now, since we have this continuous need for forensic pathologist, why it is we have not been able to address that with the number of doctors that are coming out of our institution year after year? Why it is this has not been addressed? And what is being done with any urgency? Because it impacts upon our national security situation at this point in time. Because pathologists' reports are essential in concluding many criminal matters, certainly homicides, and right now it is woefully inadequate. What are we doing? It is being attended to with any urgency?

Dr. Misir: Again, Chair, thanks for the question, and again let me try and put things in context. So, the forensic pathologists are employed by the Ministry of National Security. Our doctors who are in the employ of the Ministry of Health or the RHA, we provide a service, what we call medi-call on-call, where, if you have somebody—somebody would have committed suicide, or a sudden death, or somebody would die maybe from natural causes in their homes, our doctors have a role to play in that particular scenario. But all of this is done for and behalf of the Ministry of National Security. So, to answer your question in terms of, we continue to advertise, we continue to offer scholarships for training in that particular area, forensic pathology, but, again, it has to be in a foreign jurisdiction. We do not have it in the University of the West Indies, right, Prof?

Prof. Seemungal: Not yet. Not yet.

Mr. Chairman: When you say, we, you mean?

Dr. Misir: I am talking about Trinidad and Tobago here. We are looking at providing the services, as you say the medical care and so on for our people. So that when I say we here I am talking about the people of Trinidad and Tobago. Now, the Ministry of Health will offer scholarships, or through negotiation as has been mentioned before, Ministry of Education, because they have the funding for scholarships. But, that doctor when they return, of course, they have to be employed by the Ministry of National Security, which is where we have the employ of our forensic pathologists.

Again, you have to have the collaboration, you have to have meeting of the minds and so on. So that in a number of areas where—now, opportunities for postgraduate training, we are looking at filling the void for specialists in the country, basically that is what we are trying to deal with. So that we have to be able to access places in foreign jurisdictions where we can get our nationals trained. That is not as easy as Prof. mentioned earlier. In the UK where historically most of our graduates would have gone to get advance training and specialized training, that now is becoming more and more difficult, and is the same thing that is happening in the English speaking countries like in America, and Europe, and Canada, and so on. So, as much as we are willing to offer the scholarships and so on, it is also dependent on the availability of training opportunities in other countries.

So, to answer your question, I mean, not only with forensic pathologists, but a number of these highly specialized areas there is a factor that we have to take into account in terms of whether or not we have availability of training opportunities, because the University of the West Indies does not have that at this point in time. So, all of these things have to be taken in account to answer the question about what are we doing to fill the void or the deficiencies that we have for specialists to provide the care for Trinidad and Tobago.

Mr. Chairman: Would it not be easier, like what they do in other instances in the police service, in other departments, where you bring in the professionals and set up the training process here, which would be cheaper? I mean, there are a number of pathologists and forensic pathologists of a certain level, they are highly skilled after a number of years, and performances of autopsies and so. I know of one that I used in a case from aboard, he was a consultant for CNN, Dr. Baden, he is a Professor at Columbia University, a top pathologist. And these people go on different tours as you may say, lecturing in different universities and so, is there not a department of pathology in the University of the West Indies per se? Not necessarily the University of Trinidad and Tobago, the University of the West Indies?

Dr. Misir: Chair, I know Prof. will probably add to the answer. Now, you are quite correct, remember pathology you are talking about forensic pathology.

Mr. Chairman: Yes.

Dr. Misir: Which is like a—

Mr. Chairman: Sub-speciality.

Dr. Misir: That is right, a sub-speciality. So that, yes, the University of the West Indies we have a training programme in pathology which is like gross pathology. Forensic pathology is highly specialized where you have to see hundreds of post-mortem with different kinds of criminal scenes and so on. Forensic pathology is not just the cadaver, not just the dead body. You actually have to go to the crime scene, look at the angle how the body was found, look at other things in the room, look for wires, anything that will help you to come to a conclusion as to what is the cause of the demise of the person. So that for our purposes in Trinidad and Tobago we have to send persons in other jurisdictions to be specialized in forensic pathology. But right now general pathology, in other words, looking at the arteries of a

diabetic, looking at some tumour/biopsies and so on, that kind of pathology training we have in the University of the West Indies, and we are sending persons to be trained in this area. But, your question had to do with forensic pathology, and that is why I am saying to you, it is a "lil bit" different.

Now, the other thing that you mentioned, and you suggested, I am telling you this, we are exploring different avenues to offer postgraduate or specialist training for doctors, and one example that you mentioned, we are considering that. We did in fact, with the University of Trinidad and Tobago and Johns Hopkins University, offer a postgraduate speciality programme in cardiology where the same method that you described, where the consultants from Johns Hopkins would have come to Trinidad for a short period, impart their technical skills and share their knowledge and so on, and they would go back, and you would have different persons coming. So, we are also looking at this modality or this avenue to train our persons, our citizens and so on, our doctors in speciality areas, but again it takes a lot to get everything in place in terms of negotiations with the other universities and so on, but we are also looking at that.

And I agree with you, rather than sending one person to train in a foreign jurisdiction, if you bring the professors then we could probably train six persons at the same that would benefit to the country. So, we are also looking at that. We are also looking with the Chinese Government, for example, where persons can get—we had the San Fernando initiative with the Chinese Government-to-Government arrangement where Chinese professionals came to Trinidad, did service, and they were also training our doctors in a highly speciality area, neurosurgery, and neurosciences. So, we are exploring all the different permutation and combination to equip our doctors and our medical providers in the speciality areas that are evolving, as we speak, and in 10 years, that is when I address the idea about the 10-year manpower plan, we are trying to predict what are the areas of need and try to get training programmes on the way to deal with these as they arise.

Miss Ramdial: Thank you. And this question is either to the PS or to Dr. Misir. Over the past year we would have heard in the public domain that there are about a hundred or more junior doctors, or persons who have completed their internship awaiting employment in the public health sector. We would have also heard in the public domain about junior doctors who have completed their DM programmes and awaiting promotions within the system. We would have also heard that there are foreign doctors in our—lots of foreign doctors in our health centres and hospitals, and I want to ask this morning, why is it taking so long to employ our junior doctors, to give promotions to our junior doctors to the DM positions, and why are we still giving preference to these foreign doctors in our country? What it is that we cannot give preference to our locally trained doctors that these foreign doctors are taking away from our local practitioners?

11. 30 a.m.

Dr. Misir: Again, thanks for the question and let me try to answer the question. Now, let me make it clear. In a

regional health authority you have an organogram which is your structure that will determine, would say, what are the different doctors, the levels, the specialty and other persons are that involved in delivery of health care.

Now, let me make it clear up front, the doctors, the foreign doctors, for example, the doctors from Cuba, they are employed and they are engaged through the Ministry of Health. So they are not occupying any positions in the RHA establishment. Let us get that clear up front. So that the opportunity for a local who is employed, it does not impact on that.

So the other thing is that, now, the time interval between receiving your DM, as you say—you alluded to the DM specialty programme—the time between that and actually filling a vacancy, of course, you must go through a process, you have to apply, you have to have interviews and so on. I mean these things take time. It is not that immediately upon receiving your DM, the next morning you will walk into a higher position. It is not as easy as that. I mean, it would be nice if it is like that for the young doctor, but it is something that has to, you have to do the evaluation, you have to have your HR, you have to have your interviews, you have to do some kind of—you know, the whole evaluation before you, because it has to be open and transparent.

Miss Ramdial: So just to cut you through there, Dr. Misir, what is the waiting time? What is the time that it would take usually in your estimation to move up with respect to junior doctors to get their promotion?

Dr. Misir: I mean, I am going to call a figure which, I mean, that may or may not, I could substantiate it tomorrow, but I am saying to you that from my experience, within six months, once there is a vacancy in the establishment you would get your promotion. Because the HR processes and so on, I mean it takes time when you do an interview you have to write up the report and so on. So it will take time plus you have to identify the funding. Remember, when you have a position in the establishment, if you do not have the money trail to go with it you just cannot put somebody there. So a number of things have to be in place before you could actually offer a promotional opportunity to a young doctor who is qualified. It is more than that.

Mrs. Baptiste-Primus: Thank you kindly, Mr. Chairman. Dr. Misir, based on the information that is before us, there are currently approximately a little over 1,200 foreign doctors employed in our system, primarily from Nigeria, Cuba and India. Am I correct? Approximately around that figure.

Dr. Misir: I do not think, I mean it might not be doctors. It might have 1,200 foreign professionals and that might include nurses, midwives and—[*Interruption*]

Mrs. Baptiste-Primus: No, medical practitioners.

Dr. Misir: Yes, it is around 1,200.

Mrs. Baptiste-Primus: Good. Now the submission by the Trinidad and Tobago Medical Association informed us as follows:

> The now defunct Parallel Medical Board introduced via an amendment to the Medical Board Act in

2007 allowed at that time over 2,000 foreign doctors to be registered to practise in our national public health system. To date, several of these doctors remain in practise locally in both public and private capacity, not all of whom are registered with the Medical Board of Trinidad and Tobago. Is that correct Prof. Seemungal?

Prof. Seemungal: Yes, that is right.

Mrs. Baptiste-Primus: And why is such a situation allowed to exist?

Prof. Seemungal: I cannot answer you, we did not set up the parallel board. What happened, and historically I do not, there must have been some rationale—[*Interruption*]

Mrs. Baptiste-Primus: Like my colleague, I just want to cut through that, we know it is not your responsibility, your appointment is of recent vintage, December 2015, but this is a situation that is existing. How is the Medical Board going to engage in the necessary corrective action?

Prof. Seemungal: We really do not know how to do that, because you see as long as somebody comes to us for registration we can deal with it. If a complaint is made to the board that somebody is doing something outside we can look into it. But we hear word that this happens but we do not know. I want to point out, the 1,209 that you see in our report on page 8 is those who are registered with us. We do not have any data on those who are not.

Mrs. Baptiste-Primus: So Prof. Seemungal, tell us therefore, what is the procedure followed by the council in verifying the authenticity of degrees and certificates by doctors seeking registration in Trinidad and Tobago. What is the procedure?

Prof. Seemungal: Okay. We have submitted that to you. If it is from—[*Interruption*]

Mrs. Baptiste-Primus: The public out there wants to know, Professor.

Prof. Seemungal: If it is from the traditional medical schools, those that we know and are accustomed to dealing with, then they have to provide the original certificate. If the school is not one that we know about or have a history of dealing with, then we wish to find out if the school is accredited.

Mrs. Baptiste-Primus: How do you do that?

Prof. Seemungal: Through the Accreditation Council of Trinidad and Tobago. So the doctor has to provide us with that evidence or we approach the ACTT. Once they show us that the school is accredited we then ask the doctor to bring in their original certificate to us. Now, the school must also be on the world council of—we have a document here, we gave a list of, I just have the list before me, but unfortunately I cannot put my fingers on it right now, but we did provide, it is in the Act. There is a list of medical schools, here it is, the World Directory of Medical Schools, page 20 of the Act I think. Once you are on that council and are accredited then again we will take the certificate. But if that is not the case then we cannot register the person.

Mrs. Baptiste-Primus: How do you all know that certificate is authentic? We have had a lot of false papers in this country. So whilst the institution may be accredited, what measures do you all take to ensure that the actual certificate

that is being presented to you all is authentic?

Prof. Seemungal: So we have that, I have to look at my documents here. [*Crosstalk*] No, no, no, we want the original. If it is an authorized copy that is also accepted. So here we have a letter of good standing from—I have here for full registry. I have the document here, submitted here, I cannot tell you off the top of my head though, but we do have a full procedure which is applied for people coming for temporary registration.

Mr. Chairman: Dr. Misir you realize that there is some uneasiness that resides in the public concerning foreign doctors being admitted to practise here. If for instance a Trinidadian doctor qualified as he may be—highly qualified from the University of the West Indies—seeks to go to the United States to practise medicine in whatever specialty he may be, you know it is not automatic by producing a certificate, he has to do some board exams. Do you think it would serve us well to implement something like that so as to deal with this lurking type of danger that we seem to be flirting with all the time?

Dr. Misir: And Chair, again I thank you for the question because it is again a very appropriate question. Now, to address this problem of admission of graduates of foreign medical schools, let me just put it under that heading. A number of things are being put into place as was mentioned. We tried to have internal processes that would actually examine the certificates, look for the embossed seal and this sort of thing. It is just to ensure that there are no fraudulent certificates and so on. But in addition to that, the graduates from foreign medical schools and so on and this is a Caricom, this is a regional thing where there is the CAMC, the Caribbean Association of Medical Councils, I think it is—Prof. could correct me—where now we are requiring that they must do this exam, just as if you want to go to North America, you have to do a state board exam depending on which state. Because we are small as a region and so on, we have this one common exam so that if you are a graduate of one of the offshore medical schools in the Caribbean and so on, you have to sit that exam and pass that exam before we could even consider at the Medical Board level for registration to practise in the country.

I mean, these are the things we are trying to put into place to deal with, as you say, the entry level and the licensing of foreign graduates. So we are trying to put things in place just to ensure that the bona fide practitioners will be allowed to practise in the country. [*Crosstalk*] Yes, yes, it is being implemented. Now, Prof. Seemungal mentioned, and I do not want to delve too much, the issue with the parallel board. Now, we find ourselves in a situation in Trinidad and Tobago where we had to establish what we called the Parallel Medical Board. Because of the shortages in the public health system we were forced to bring in doctors from other schools and so on and the licensing with the Medical Board and so on, it was not being done as readily as the Ministry would have wanted and that was something that was short term and it has come to an end now.

Now, we find ourselves in a situation where these very graduates who were performing and functioning in our system they are here whether they become naturalized and so on, the issue here is that how do they get to be able

to continue to practise in Trinidad and Tobago so that with the current Medical Board and Medical Council and so on, we are trying to give them guidance, give them the opportunity to pass their exams and so on, so that they could continue to practise.

So there is a number of permutations that we are using to deal with the situation. What I mean, Chair, through you, and I am going to say this now, I am a little bit perturbed by the submission that you mentioned from the Trinidad and Tobago Medical Association, where they are saying that they are aware that we have a number of people who are practising, who are probably not properly registered with the Medical Board and that information I think should be shared with the Medical Board for us to action, please.

Mr. Chairman: Sure.

Prof. Seemungal: Chair, if I may, I can now give a more detailed answer to Mrs. Baptiste-Primus' question. A foreign medical doctor who wishes to practise here gets temporary registration for a maximum of three years. They must submit their original certified copies of their medical degree, postgrad qualifications and an original certified copy. They must also produce a letter of good standing from their current registration body which must not be more than three months old. That is the letter. They must provide a certified copy of their current licence to practise in their jurisdiction from which they are coming and, of course, certified copy of an identity for their passport. Now, once they get into the system, so we agree we have a few other qualifications such as the ability to speak English. We have a few other criteria and then of course a valid job offer from a local regional health authority.

Now, once you get into the system we have an assessment that has to be completed every year. So in order for them to continue getting their temporary registration, and the assessment has to be done by the supervising doctor. They are only allowed to work in institutions where they will be closely supervised, such as, area hospital, Point Fortin, Caura Hospital the General Hospitals in the country and St. James Medical Complex, Queen's Park Counselling Centre and some of the district health facilities, so that they must be supervised. Once they pass the supervision for three years they then go through the other criteria that have to be used so that they can get full registration. Thank you.

Mr. Chairman: This question is for Mr. Benjamin. I know he probably may have felt left out and we would not want him to leave here from NIPDEC. And I know my colleagues here may have quite a bit of questions for you and I see we are running out of time. So I would like to pose the first question to you in terms of the procedure. You know, people are concerned over the last year or more of the lack of drugs being able to access at the public hospitals. And NIPDEC through some protracted or some convoluted process, in terms of purchasing drugs on behalf of the regional health authorities, seem to either be sticking for whatever it is, for whatever reason it is and I think the public today would really like to get an understanding what exactly is NIPDEC's role in procuring drugs, pharmaceuticals on behalf of the necessary health institutions in Trinidad and Tobago. In as succinct to where you can, please explain.

Mr. Benjamin: All right, thank you. First of all I think we need to understand that there are some, there is probably not as convoluted a system as you may think. There is a very standard system that is in place for getting drugs in Trinidad. NIPDEC's role is at the wholesale level. We are the agency that procures in bulk drugs for the whole health system. We then have to store it which we do at our C-40 warehouse in Chaguaramas and we then distribute it. The distribution is for the institutions largely that are run by the RHAs. Pretty much, about 91 to 92 per cent of it goes to those institutions. There is another 8 to 9 per cent that goes to CDAP. CDAP is the most strongly branded aspect of the distribution system. Everybody thinks of drugs and they think of CDAP, but in fact more than 90 per cent of the drugs we distribute do not go to CDAP, they go to the institutions, the hospitals, the programmes of the Minister of Health.

I said that we operate at the wholesale level because I think that is something that people need to understand. There is a whole supply chain for pharmaceuticals and it starts with the international manufacturers, the manufacturers of the active agents, the people who do the preparation of the actual medical preparations. It involves the international distributors and the logistic centres abroad, and they are the ones from whom local private distributors get their supplies.

So those supplies come to the private distributors here. Those private distributors are who supply NIPDEC. When we have a tender process, NIPDEC managers the process of tendering every year and we buy from those local distributors. There are some international distributors that we buy from as well but most of the drugs come from local distributors who then get it from abroad.

Now, you need to understand that supply chain, both where the drugs come from and where they go to.

Mr. Chairman: Just to ask you a question quickly, just put a pin there. So you said you procure drugs from local distributors, but does that in itself add additional cost for your procurement process?

Mr. Benjamin: We do not know how much it adds, we do not ask about their profit margins.

Mr. Chairman: You are not interested in it?

Mr. Benjamin: The process does not involve—[*Interruption*]

Mr. Chairman: How you can get a better price for the public.

Mr. Benjamin: Yes, we are. And we will come back to that. We will talk about that in a minute because remember we are just service providers to the Ministry of Health and so the Ministry of Health will tell you that they have initiatives now including interface with PAHO, where we are looking at opportunities of getting drugs directly from PAHO and that can address some of the markup issues probably with the private distributors.

However, let me just say, there is a process, there is a tender process and the private distributors from who we buy, they tender their prices just like in any other tender process; exactly what their markups are over what they paid to the international distributors, we do not necessarily know. We can guess because we can go to the international

markets and look and see what happens in other markets probably.

Mr. Chairman: I do not like what I am hearing. What you are saying basically to us is that you have a remit which is to procure drugs on behalf of the public. Yes?

Mr. Benjamin: Yes.

Mr. Chairman: Okay. And you are to get those drugs at any price? Is this what you are saying?

Mr. Benjamin: We have a competitive tender process which we put out to do—[*Interruption*]

Mr. Chairman: Yeah, but what you are saying, you do not know what the generic price would be or what profit or whether you can get it in existence from where it is a cheaper price. This is what you are saying? You are saying that you are not interested in knowing what their markup is?

Mr. Benjamin: Okay, I think you asking as to whether or not we do a global search. The answer is no, we do not. We put out tenders to the public—[*Interruption*]

Mrs. Baptiste-Primus: Excuse me, Mr. Benjamin. We appreciate the information flow that you are giving. But I think what the Chairman is attempting to extract from you—do you all engage in any analysis in terms of getting the best price and value for money? I think that is what he wants to find out.

Mr. Benjamin: Okay. So let me step back a bit. There are a couple of ways you can do that. One way you can do it is by doing a global search. You look and see what the prices are in different—[*Interruption*]

Mrs. Baptiste-Primus: Do you all—[*Interruption*]

Mr. Benjamin: Can I finish?

Mrs. Baptiste-Primus: No, you are engaging in a generic discussion but what we want to find out is, what do you do? Do you do that?

Mr. Benjamin: What we do is a tender process just as if I am going to build a building, I say what I want. I send a tender out to the market. Everybody has to compete. They then tell me what prices they are willing to sell me at. They have to compete and whoever gives the best conditions and prices we will buy from them.

Mr. Chairman: Mr. Benjamin, how would you know what is the best prices if you do not know what the product is being offered at anywhere. How would you know?

Mr. Benjamin: All right, how does a tender process work? It is a legal process.

Mr. Chairman: No, no.

Mr. Benjamin: Hold on, let me finish, let me finish, please.

Mr. Chairman: No, Mr. Benjamin. Let us pause for a while. If I want to buy apples and I put out a tender for apples, I either put a mark I am looking for apples between 10 to 25 cents so I know at least the minimum or maximum may be and who comes in within that I will then with the other conditionalities choose that. This is what I am asking you. Before you put a tender out do you know what range of prices you are looking for in any of these drugs? So you could

get a tender for $1 million and somebody put $5 million and at the end of the day the drugs really are obtainable at $100,000 somewhere else. So how would you know you are getting good price for your money?

Mr. Benjamin: Well, one of the things you will know about the pharmaceutical business and I have to come back to supply chain in a minute because I think we need to understand the supply chain as well. The pharmaceutical business is one that is governed by, like many other commercial things, arrangements with the manufacturers and the international distributors where there are local distributors of specific drugs, especially the branded drugs. There is more competition among the generics, but the branded drugs are the subject of legal arrangements with the international manufacturers and distributors of those drugs. We do not control that. Those are facts that are there that we have to deal with.

So when we put out a tender, who is supplying which drugs and what pricing levels they are supplying it at is controlled by a set of agreements outside of us. There is competition as I said among things like generics and so on and we are supposed to try and get the best price from the competitive process. We know from looking at the international market and we can look at particular drugs individually, let us say, that in other markets in America, maybe, in England, in Canada the prices of some of these drugs are different. Can we expect to have the same pricing as they have in those markets?—no, that is not how markets work.

And so in our market, subject to the legal arrangements between the distributors and the international manufacturers the prices are offered to us. And this is why I mentioned the Ministry of Health and I mentioned the Ministry of Health's initiatives with PAHO. Because what the Ministry of Health is doing, and I will let them speak for themselves on this matter, is that when we look at the world market and the world market has some drugs available at lower cost we have an agency like PAHO who can buy in bulk. One of the things you need to understand is the level of demand in Trinidad is very tiny. We are not a price maker. We are a price taker. We are very tiny, we are almost a nuisance buyer on the world market. When we go to people like PAHO who can buy in great bulk they can get lower prices, they do get lower prices and we are actually trying to get access to that now.

Mrs. Baptiste-Primus: So, Mr. Benjamin permit me, you mentioned going through PAHO to buy drugs. When was such a decision taken?

Mr. Benjamin: The Ministry of Health, we are just—remember we are a service provider to the Ministry of Health. Policy decisions are taken there.

Mrs. Baptiste-Primus: Mr. Benjamin, when was the decision taken to go through PAHO to purchase drugs?

Mr. Benjamin: I think the Ministry of Health has to answer those questions. I am just telling you something I happen to know about what they are doing. It is not NIPDEC doing that.

Mrs. Baptiste-Primus: You were the one who mentioned purchasing drugs through PAHO. How long have you been purchasing drugs through PAHO?

Mr. Benjamin: We are not even doing it yet. It is an initiative that has started. I want the Ministry of Health to talk. Dr. Misir, can you inform them?

Mr. Chairman: Mr. Benjamin, is it you are seeking assistance?

Mr. Benjamin: No, I am not seeking assistance but I am giving you facts. The fact is that it is not—okay, let us start again.

Mrs. Baptiste-Primus: So, Mr. Benjamin, hold a second.

Mr. Benjamin: Let me answer the Chairman.

Mrs. Baptiste-Primus: Mr. Benjamin hold a second, please. You are here at our behest, hold a second. What is the procedure in place now?—you are dealing with PAHO which is a new initiative and the initiative that would save this country millions and millions of dollars and we commend such an approach. Prior to this new initiative, what was the procedure?

Mr. Benjamin: Right, so we have a procedure, let me let the head of pharmaceuticals tell you some of the details because we have it well documented here. We actually have packages that we can give you that have some of the details.

Mr. Chairman: Ms. Austin we would like to hear from you now.

Ms. Austin: Good morning everyone, good morning Chairman.

Mr. Chairman: Good morning.

Ms. Austin: I would just like to say, firstly, there is a little uniqueness in the pharmaceutical industry in that we are governed by certain legislation, patents and registration of drugs. Now, this would affect the ability to procure drugs at a cost that may be considered relatively cheap. In Trinidad and Tobago there is a finite list of registered drugs. We are not allowed to purchase unregistered drugs for the use of the population. This is a limiting factor in terms of the pricing available. So what we would currently, at this time, what we currently would pursue for items that there is more than one—[*Interruption*]

Mr. Chairman: Ms. Austin, you are a bit too close to the mike. Just lean back.

Ms. Austin: Okay, sorry about that. We first would look at the purchasing of generic drugs if they are registered in this country. The second thing we would look at, we use the process of the competitive tendering to procure registered drugs at the most affordable price. Now, I need to emphasize that simply because we cannot look at a drug that may be cheaper, internationally, and simply just purchase it in our setting. So at this point in time the option of using a competitive tender provides for us the most value for money. Mr. Benjamin spoke about the introduction or engaging PAHO from this tender period and the PAHO initiative serves a twofold purpose. One, we can use PAHO price estimates to compare with our local distributors. So there is not a necessity to purchase either from PAHO or from the local distributor. We use a comparator.

Secondly, for items that are not registered but are available in first world countries and are registered in first world countries and are used in first world countries, that offers us a second comparator. We cannot compare drugs that are not registered. So there may be drugs cheaper, internationally, but once they are not registered in this country we are not allowed to purchase. I do not know if I am answering the question that Mrs. Baptiste-Primus was asking?

Mrs. Baptiste-Primus: Yes, indeed you have been rather helpful. But I just want to find out, what is the value of expired drugs over the last three years or so at NIPDEC, the value of expired drugs?

Ms. Austin: Well currently we have for six years, we have approximately $63million.

Mrs. Baptiste-Primus: So $63 million, this is six years, four years, one year, Dr. Misir, is a lot of money.

Ms. Austin: Sorry, five years.

Mrs. Baptiste-Primus: Sixty-three million dollars. What accounts for that?

Ms. Austin: So there are several factors. Firstly, I would like to start by saying the returns from RHAs—now, we have a situation currently where the drugs that are currently stored at the RHA level—"we" meaning NIPDEC, we do not have access to the stock on hand or the inventory, direct access.

12.00 noon

We are aware of the returns when they are sent to central stores within either two or three months of the expiry date. At that point in time we are unable to redistribute the stock. Secondly, we have had instances, particularly, in the non-pharmaceutical industry where the decisions taken at the Evaluation Committee are not adhered to by the users in the institutions. So there is the issue of brand loyalty and we have examples of that which we can provide subsequently if asked. So that is the second major reason for the large value of expired products at the central stores warehouse. The third issue, and is also very prevalent right now, we have items that may have been awarded, for example, generics, that are not used very often at the institution level.

Now we, meaning Nipdec, we do have the authority to force a user at the institution to utilize the drugs. We have the option of going to the Ministry of Health, to the Office of the CMO, who strongly supports our initiatives to try to move the stock. Without a nationwide health information system, where we can actually see the inventory levels at the institutions, we are actually in the dark. So we are not aware that these large quantities—so sometimes when they speak about stock-out at the institutions, it is not that there necessarily is a stock-out in the health system, but where the drugs are being stored it is not equitably distributed.

Mr. Chairman: Miss Austin, just to interrupt here a second. What is the core competence of Nipdec? What is the main function at Nipdec in the system, in the public space?

Ms. Austin: So our first core competency is the procurement of the pharmaceuticals and non-pharmaceuticals for the public use; the second would be the storage of these items; and thirdly, the distribution to the users or the secondary users which would be the institutions and the retail pharmacies.

Miss Ramdial: So for redistribution purposes of stock before it expires, is there anything being done either by Nipdec, or the Ministry of Health, to correct the situation so that we do not lose so much money?

Ms. Austin: Yes, we actually had an initiative that originated at Nipdec, where we have these WhatsApp chats among the pharmacists at the different—well we have for HIV and then there is also one for the public pharmacists. So this actually has increased coordination and communication. We also liaise very closely with the principal pharmacist, and most recently for the CNS drugs—the central nervous system medications—we have discovered that whilst we may not have stock at central stores, there is a lot of availability within the region. So Ms. Grimes, the pharmacist, she has actually—we have a manual process of redistributing the stock based on the reports at the RHAs through the regional pharmacists, the principal pharmacists and ourselves.

Miss Ramdial: Just a quick follow-up. What about lifesaving drugs, like the drugs for cancer, can you elaborate a little bit about that; and in recent times we have had shortages in the cancer drugs, can you expound on that a little bit?

Ms. Austin: Yes, again it speaks to the issue of funding. Now the issue of lead times is very significant. Mr. Benjamin had mentioned initially that the medications are provided from international suppliers, and for the majority of times there is approximately two to three, sometimes even six months lead time. The lead time is very important to prevent the stock-out situation, and to ensure that we are ordering on time to prevent the stock-out, you also need to receive adequate funding and funding in a timely manner.

Now what we have done in the interim, particularly for this year to try to avoid a similar situation, we are trying to procure for longer periods. To incorporate the lead times, we have seen an average of probably about three-month lead times for most of the suppliers and we also engage the suppliers if there is any locally available stock that they can advance us—so that this is through the tender awards—and we would send to the major users, for example, St. James medical facility, the Sangre Grande or San Fernando, the major hospitals.

Mr. De Freitas: I just wanted to go back and touch on the question regarding public sector versus private sector and the question I wanted to ask—because the main factor in here in terms of demand from the public sector in regard to drugs and what not—is: what mechanisms are in place to prevent doctors from utilizing resources allocated to public health facilities to support or aid their private practice? Ministry of Health?

Mr. Madray: Well I know it may not be good to say that I am not sure. I really would have to be in the RHA to know what those processes may be in place there. I cannot say that I am aware of any information that suggest that there is a major issue, but that does not say that there may not be. We can, of course, ask for this information and provide it if necessary.

Mr. De Freitas: I think for all concerned and for the public in general, we would like to have that information if there is an issue.

Mrs. Baptiste-Primus: Thank you kindly, Mr. Chairman. Just two questions to Mr. Benjamin and Miss—I am sorry, I did—Miss Austin. Thank you kindly, Miss Austin, for elucidating on the process, but may I enquire how wide is the band of drugs purchased by Nipdec, and whether or not that is not a factor in there being $63 million in expired drugs?

Mr. Benjamin: Okay, let me say two things. One, the number of drugs that are on the approved list, we have a formulary in Trinidad that is probably at a level of about thousand drugs if the Ministry of Health can confirm. That is a very, very large figure compared to international standards.

Mrs. Baptiste-Primus: That is an understatement, Mr. Benjamin.

Mr. Benjamin: Yes, it is indeed. There are large countries which have formularies in the region of 300 drugs. So a thousand is really out of the range. Included in that, several different versions of the same class of drugs; included in that are drugs which are branded drugs, expensive branded drugs even where there are generic alternatives. One of the initiatives that is currently starting is that the Ministry—and the Minister of Health in particular has taken this issue up—is to get the number of drugs in the formulary down, to actually manage that down, to purchase fewer of the same type of drugs, to purchase fewer branded drugs, to make better use of generics, that sort of thing because that alone will save us probably at a—

Mrs. Baptiste-Primus: So you are in line of the process of reviewing.

Mr. Benjamin: Yes.

Mrs. Baptiste-Primus: Thank you, kindly.

Mr. Benjamin: About the expiries though, one of the things is that we are not in control at Nipdec of what happens with the expiries, except insofar as it relates to stocking our warehouse because one of the things that happens is that RHAs will have drugs and will hold on to them, will decide to send them back to Nipdec when they are approaching expiry, but very often by that time you cannot do anything with them.

The arrangements we have now are such that if the drugs are returned in sufficient time, we may actually be able to return them to the vendors and get some credit back for them, but when they come back to us last minute we end up with piles of expired drugs with which we can do nothing at all essentially.

Mrs. Baptiste-Primus: And in that context, have you all made any recommendations to the Ministry of Health who has oversight over all the RHAs?

Mr. Benjamin: Yes. There was in fact very recently a stakeholders meeting where all the major stakeholders of the health sector were brought together and a number of the issues affecting the pharmaceuticals supply chain were discussed and suggestions for improvements were made and, in particular, this was discussed and the whole business of vendor returns, which is a standard option in the supplier contracts. It was reiterated that this is something that people have to pay attention to, the RHAs have to pay attention to, you return the drugs in time, you keep track of

your expiries in your stock and you make sure you return them in time so that we can get credits for them.

Mrs. Baptiste-Primus: I thank you kindly. Mr. Chairman, my final question to either Prof. Seemungal, or Dr. Misir, but I think firstly Prof. Seemungal. With regard to recommendations from the Board for the amendment of the Act, did your Board make any provision for whistleblowing mechanisms through which complaints against medical doctors can be lodged?

Prof. Seemungal: No, it is not in those, but it is in our Code of Ethics, on page 19 of the Code of Ethics, to which all doctors are supposed to subscribe in Trinidad and Tobago. It says that:

> "• Patients must be protected from a colleague whose conduct, competence or health is questionable. The concern raised should be dealt with expeditiously, and must override personal or professional loyalties.

And,

> "• Where there is a suspicion that criminal activity has taken place, and in particular in cases of alleged sexual assault, a police report must be made."

Mrs. Baptiste-Primus: But Prof. Seemungal, do you not think while one appreciates that it is in your code of conduct, that provision ought to be made in the legislation so it gives it more teeth.

Prof. Seemungal: Yes.

Miss Ramdial: Just going back to Nipdec, probably Nipdec or the PS at the Ministry of Health can answer this question. An initiative was undertaken a couple of years ago, millions of dollars was spent by the Ministry of Health with respect to the health card project—and I think what Nipdec is talking about and the Ministry of Health in terms of distribution and demand and supply of pharmaceuticals within the health sector has to do a lot with creating that database with which the health card project would have brought into with respect to that system—what is happening to that project because we think that that was a very good initiative, the health card in terms of tracking especially CDAP and the pharmaceuticals with the CDPA associated with the CDPA programme, can you give us an update with that with respect to that project; and whether or not in your estimation it was a good project to track the pharmaceuticals supply within this programme?

Mr. Benjamin: Actually the idea behind it was excellent and had a number of elements that would have been necessary for having an efficient health system, however, we have found in practice the implementation has left quite a bit to be desired. So we have implemented the system, and if you go to your pharmacies you would see a number of them with their fancy terminals for the National Health Card system which is one of two systems still in use actually. The old system with the terminals is still in use, however, we have had performance problems with the new system. We have not been able to get the data transferred back to the central database, we have not been able to get the reports generated, and while all of the major modules have supposedly been completed we are at this time in talks with the

developer and their foreign software support developers. We have been talking to them on the basis of: how do you fix the system, because right now it is not performing how it is supposed to perform.

We have spent a lot of money on it, we have hope for it, we have great need of if, and I want to just step away from just the National Health Card for a minute to tell you how important what you just said is about the information in the system. This year we spent a lot of time trying to get funding for the pharmaceuticals. Funding is one of the biggest issues that have come up in terms of shortages, however, even putting together the Cabinet Note to request that funding requires something else. It requires information; it requires up-to-date information on the state of the system, the levels of stock, where that stock is, what the levels of usage of that stock are, that sort of thing.

In the absence of a comprehensive system, in the absence of an integrated system that keeps track of that information and delivers that information into the hands of the people who have to do the planning and who have to develop the Cabinet Notes and so on, we have a huge problem. We cannot generate the information on time, we therefore cannot get the funding on time, we therefore cannot get the drugs on time, so we have an issue. One of the biggest initiatives we have to have, and I think Dr. Misir and the people at the Ministry of Health are very much on board with this, is the introduction of an integrated inventory management system for the health sector and, of course, the National Health Card was implemented for CDAP.

CDAP as I tell you is a 9 per cent of the national system. We need a system to cover the whole of the national health system drug movements, but that information and those databases that you talk about, you are correct. They are extremely important. Right now they created quite a problem this year for being able to generate the data for planning that we need, and I know that we will need to track the progress of that initiative. But the National Health Card system itself, I do not know what the doctors would call it. We have gone past triage. We are now into trying to do treatment to see if we can get a remedy for it.

Mr. Chairman: Thank you. Mr. Benjamin, thanks very much for that discourse. At this point in time, we are at 12.16 p.m. and we are nearing our completion of this hearing. So before I draw it to an adjournment, I would like to thank all the members for attending this morning and participating as you have done. I would like to thank the listening public that "does be listening". Health in Trinidad and Tobago, health care, the provision of health services in Trinidad and Tobago is very dear to all of us. Unfortunately, it is not if, but a matter when somebody would be in need of health services in Trinidad and Tobago. For a small country of 1.3 million people, we have a proliferation of private facilities and significant number of health facilities, and yet still we cannot boast of being offering at premium health service in the region.

This morning as much as it has been the light in terms of the information that is being elucidate of being put into the public domain, there is a lot more questions than answers that are comforting I am sure to the discerning public. I, for one, has sat in about four or five hearings thus far and this has been the most uncomfortable one for me

in terms of the information that is coming and not coming. I am totally uneasy and I am hoping that with my other members at some point in time we will all be able to bring you all back here again where much more potent and information that is more comforting, and that will be put in the public space, so we will know where we are with our health system.

It is just as critical as our national security situation in the country. Our health system has been crying out for an attention for the longest while, money has been throwing, millions and billions, and it has not improved significantly where we can feel comfortable. You all will want to know that you fall sick and you can walk in to any institution, public or private, and get the best that there is without any hesitation. That you will go in alive and come out alive, not go in alive and end up dead. Go in for a minor thing and end up with a major thing. These are the concerns. These are real concerns for our country, real concerns for all of us. You members who are doctors, who are health providers, at some point in time you yourself will be in need of it and I know doctors who provide medical services and when they get sick they fly out. So that tells you something. It really tells you something that is very disquieting.

So in closing, I would like to thank you all again. I would like to thank the members for participating and I would invite Prof. Seemungal to give a brief closing remark, as well after Dr. Misir, and then after Mr. Benjamin. So Prof. Seemungal. And Permanent Secretary as well.

Prof. Seemungal: Yes. Thank you, Chairman. Would the suggestions or conclusions of the Committee be sent to the Medical Board for action? I did make some notes here on the suggestions that you made, but I do not know how complete I was.

Mr. Chairman: A report is going to be concluded at the end of this when we sit and deliberate and go over all that has been exchanged, and then after that we will make recommendations.

Prof. Seemungal: Okay. So if that is done we will certainly follow-up on it. Thank you.

Dr. Misir: Well I would just like to thank you, Chair, and members for the opportunity here today. It has been a useful discussion I believe. The Ministry of Health has a number of initiatives that we are hoping it will address some of these challenges. It will continue to be a work in progress for some time, but we are determined to find a way of improving the quality of the health service to our citizens, and we have a very committed team at the Ministry that is working very hard at making sure that we develop the policies and strategies that hopefully will do exactly that. Thank you.

Mr. Madray: So ditto to the PS and ditto to Prof. Seemungal. Thank you all very much for giving me the opportunity.

Prof. Seemungal: Chair, there is one thing if I may? If you look at section 20 of the Medical Board Act, it says virtually every change—sorry. It says section 20 of Medical Board Act which defines the Powers of Council, says that almost any change that the council wants to make is subject to agreement by the Board, and that is a very difficult

thing because you can imagine it is difficult to get consensus amongst a Board of about 5,000 people. So perhaps one of your recommendations might be that that should be revised. I certainly think it should, but I would leave it to you all to come to you all conclusions. Thank you.

Mr. Benjamin: Thank you again members of the Committee. Thanks for the opportunity to sharing some information here. Having got involved in this area, I have come to understand that it is a far larger and more complex issue can be discussed in even an hour or two hours, and I think you are correct in that there are other aspects that will have to be explored at another opportunity, we would be only too glad. Nipdec operations under the policy and procedure guidelines of the Ministry of Health and we work closely with them in both looking at the problems and finding solutions, and we will continue to do that and continue to share the information.

Mr. Chairman: Thank you very you much. Before I close, I would just like to make a public announcement. The first report on an inquiry into the Land Settlement Agency in relation to squatter's regularization was presented in the House of Representatives on Wednesday, November 09, 2016, and will be available on the Parliament's website from Tuesday, November 15, 2016.

Again, I would like to thank all present and all listening for your attendance and I would like to bring this enquiry to an adjournment. Thank you very much.

12.23 p.m.: *Meeting adjourned*.

Appendix III

Current Members of Council

(2014-2017)

The current council was appointed in 2014 and comprises the following 10 persons:

1. **President - Professor Terence Anand Rao Seemungal**
2. **Vice-President - Dr. Dev Ramoutar**
3. **Secretary - Dir. Nathaniel Duke**
4. **Treasurer - Dr. Varma Deyalsingh**
5. **Member of Council - Dr. Kavi Davindra Capildeo**
6. **Member of Council - Dr. Andy Bhagwandass**
7. **Member of Council - Dr. Ramashawardath (Boysie) Mahabir**
8. **Member of Council - Mrs. Lynette Seebaran-Suite**
9. **Member of Council - Mr. Anthony Pierre**
10. **Member of Council - Pundit Lutchmidath Persad-Maharaj**

Appendix IV

Grounds for legal action to be taken against the MBTT

Grounds for legal action to be taken against the MBTT

The MBTT has been subjected to legal challenges over the past fifteen (15) years. However, such matters have been resolved. The following are the grounds on which legal action was taken against MBTT:

- ✓ Excess of jurisdiction due to the absence of a complaint or prima facie grounds to suggest that the report had been altered by the Appellant;
- ✓ Procedural irregularity in the failure to formulate a charge against the Appellant, the failure to take evidence on oath, the improper participation of the Council's legal assessor and the admission of irrelevant evidence as to negligence;
- ✓ The failure of natural justice by permitting absent members of the Council to adjudicate by:
    1. the taking of evidence in the absence of the Appellant or his attorney-at-law;

2. the alteration of the evidence; and
3. the refusal to permit cross-examination as to witnesses' precious statements.

- ✓ Fundamental and unconstitutional failure to protect against self-incrimination, i.e. ensuring presumption of innocence and ensuring a fair hearing before an impartial tribunal;
- ✓ The improper conflation of investigatory and adjudicatory functions;
- ✓ The improper assessment of a purported concession:
    1. as the decision is unreasonable and contrary to the evidence; and
    2. as the evidence lacked the quality of the high standard of proof required.
- ✓ The failure to read, interpret and apply the Act in harmony with the common law right to practice one's profession without being unjustly excluded from it; and
- ✓ Arbitrariness/irrationality.