Special General Meeting June 25

th 2024

Address to Members of the Board

(Rajiv Seereeram)

Esteemed Members of the Board and Council

We have called this urgent general meeting to address a burgeoning threat to the our governing

legislation, in which, among other things the status of our member designation is undermined and

the integrity and transparency of our Boards operations are compromised. Most physicians have

had little interest in Medical Governance, and only a few have dedicated time and effort to this

important task. However physicians must understand that they are part of a noble fraternity,

whose duties expand beyond bedside medicine, into the sphere of ethics, public health and

collective clinical governance. The Medical Board being the common forum and regulator of all

such dimensions of practice, must always be administered with integrity and transparency for our

fraternity to thrive. Ultimately, Our Act serves three essential purposes: it facilitates good

corporate governance of our Board, guides and protects physicians in their practice, and

simultaneously safeguards the health, well-being, and rights of the public.

It was therefore staggering that during the March 6

th Special General Meeting, as the Board was

consulted on two ancillary regulations pertaining to CME and Specialist Registration, the

council informed us, that in no uncertain terms the foundational Amendments to the Act were

merely “for noting” and that the draft amendments were “expected to be shortly laid before

Parliament”. Despite the extraordinary constitutional amendments proposed, it would seem that

approval by the General Membership of the Board was immaterial and endorsement would not be

sought.

In that meeting the point was raised that the Boards consummate objection to the CME regulations

were ineffectual in addressing the Memberships core grievance with the premature CME mandate, as

the clause which enforced said mandate was actually a proposal in the Act (Section 12B). At that

time, a healthy representation of the Board, overwhelmingly down-voted the CME provisions

Furthermore the proposed amendments included other concerning changes

1. A demotion in designation from Member of the Board to Registrants ignominiously defined

as “a person registered under this act”

2. the inclusion of an unreasonably vague “Exemption from Liability” section which could

be invoked to shield the Council from lapses in financial accountability or fiduciary

duty

3. The inclusion of an Ex Officio General Manger on council with overlapping executive

functions and unlimited term limits..

Equally concerning, the amendments failed to address any of the legacy issues that plagued our

operations such as

- lack of clear fiduciary accountability provisions,
- Insufficient transparency in committees,
- provisions for internal and external Audit and
- Lack of comprehensive Bioethics safeguards against malpractice and provisions for

patient rights

When challenged about the declaration that the Amendments were being sent to Parliament in

circumvention of the Boards approval a member of council furtively suggested that this chain of

events was inevitable and we should seek representation from our Parliamentarians if we wished

to influence the outcome. In my humble opinion this was misguided and autocratic.

Any proposed legislative amendments which can be interpreted to fundamentally change the

constitution of the Board and its authority structure, should be the subject of a series of

General meetings, during which time the Membership of the Board is thoroughly appraised and

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respectfully consulted. Amendments to our Act cannot be the purview of closed door committee

meetings, which if anything should only come after the concerns of the Board are earnestly sought and obtained. Circumventing the Board, was a slight of hand, that undermines trust in the loyalty of our Council and it is a blatant disregard for the inherent Authority and function of the Board in self governance.

In an effort to safeguard our legislation and bring attention to this existential constitutional threat, we triggered an SGM, which is a core mechanism of self governance yet preserved in our Act.

For context, unlike the GMC and other regulatory agencies which preside over practitioners, The Medical Board of Trinidad and Tobago as established in 1814 and then reconstituted in 1961 is exceptional in its latent provisions for self governance, and the Authority of its Membership through the Council is evident in its constitutional legacy.

The Corporate structure of a Board, in and of itself, refers to an egalitarian Group of members, collectively responsible for the governance of both their organization and the rules which apply to it.

QUOTE: “all persons who at any time heretofore have obtained a license of the Governor to practice medicine (physic) and surgery in the Colony, and all persons who shall be admitted to practise medicine (physic) and surgery as hereinafter mentioned, shall form and constitute a Board, to be called '(The Medical Board of the Island of Trinidad) " Section 2 1845

Despite being a body corporate in modern law, the intention for governance as a professional society is inherent and to date the designation of “member” is clearly enshrined in the act to mean “Member of the Board” implying that he/she is a formative unit of a professional Society established for the purpose of professional self regulation.

The President of a working council which includes a vice president and secretary/treasure, entirely elected by the Board, may convene General meetings where

QUOTE“the Medical Board [meaning the Members of the Board and Council] may make rules and bye-laws for the government of themselves and their affairs, and for applying and using the funds of the said Board for the purposes of such

Board in such manner as they shall see fit, Provided always, that such rules and bye-laws shall not be in any manner contrary to this Ordinance.;"Section 17 Medical Board Ordince 1845

In the modern incarnation of the Act; The authority of the Board Membership is carried forward in Section 20.(1)"The Council, subject to the approval of the Board, shall have power to make such Rules or Regulations as it deems necessary for carrying the purposes and provisions of this Act into effect,"

While some may argue that the Act doesn't explicitly provide for the Board's input in its own authorship, this is, in our view, a perilous oversight. No other entity—be it professional body, bureaucrat, politician, or external agency like WHO or GMC—possesses the relevant knowledge, experience, or qualifications to evolve our legislation as do the members of our Fraternity.

Despite the undoubted qualifications of the Council, Minister, Law Review Commission, or any committee, the collective expertise and insight of our General Membership—comprising thousands of experienced practitioners across numerous fields—is unparalleled in its capacity to shape our governance instruments, whether Rules, Regulations, or the Act itself.

Unsurprisingly, the Council has been consulting with External agencies (e.g. GMC Services International GMCSI) and working though Board Committees to inform amendments to the Act. However the composition and deliberations of these past and present committees are opaque and in

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our humble opinion are premature if they begin their meetings before securing the input of the Board. Furthermore, there is no justification for covertness in the operations of these Committees.

In the lead up to this referendum, I have asked for evidence of Council communications with the Ministry of Health, the LRC or the Parliament expressing our explicit objection to ACTs

amendments, pending our input and approval. This objection encompasses all aspects of the CME

mandate, including the sections of the ACT which enable it. To date despite the councils

insistence that the issue is being remedied though is committees we have received no evidence of

official communications with the MOH relaying the Boards explicit objection to the Act. Without

this, we can have no confidence that the act amendments, including the premature CME mandates,

are not fast-tracked to Parliament, before the committees finish their work.

Communications with the membership regarding the background and purpose of this meeting have

been frustrated as well. Despite multiple appeals our preface explaining the core rationale and

importance of the meeting was never properly displayed in the Notice. In fact the scrambled

meeting title and the Accompanying letter circulated on the 10

th June confused members and

potentially dissuaded their attendance. Requests to have the most current referendum and

Proposed Amendments circulated have not been met and a Request for the member mailing list was

not acknowledged. As Members should have the facility of the Secretariat to circulate

professional communications to other members of the Board, once such messages are relevant,

factual and important. Vetting by the Secretary is acceptable, however the mailing list should

never be guarded for the purpose of stymieing communications within the Board. Undoubtedly if

the Boards membership is clearly and adequately notified of the purpose and gravity of this

referendum the attendance would equal or exceed the last SGM attendance on March 6

th. Maximal

input from the membership of the Board is integral at this stage.

Reference is now made to the Referendum and its supplementary document the Model Proposed

Amendments to the Act, which features our edits in Blue and the prior edits in red.

The points of referendum are not an exhaustive representation of all proposed changes to the Act.

They focus on resolving issues surrounding the premature CME mandate, maintaining Integral "Membership" status, the inclusion of a comprehensive section for Financial Accountability and

Fiduciary Duty, the addition of an Auditor on Council and the amendment of a comprehensive

Bioethics section.

Firstly we propose that Clause 12B, which predicates renewal of registration on the submission

of CME points, be struck until a transparently functioning CME accounting system is established.

The CME program recommendations contained in the 2017 Ministry of Health's Submission to the

Joint Select Committee, co-authored by Professor Seemungal are still relevant:

I. set out the framework of principles and behaviors 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;

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.

We insist that these services should be incorporated in an online platform that contains

1. a list of recognized CME providers,

2. categories of CMEs,

3. clear guidance for the Registration of local providers, and

4. a conveniently accessible database for the contemporaneous collation of points.

There should be no delay in the establishment of this system, which should begin testing as soon

as possible. As far as possible the system should be automated to enhance efficiency and

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eliminate human error. Once this system comes online it should be tested for a reasonable time

(1-3 years) before the prospect of a mandate is revisited. We also suggest that retirees are

permitted some concession in CME points which is to be determined by the Board.

We take the point that in order for the Tribunals to carry out their investigative and disciplinary functions, the council requires a measure of indemnity to protect tribunal members from exposure to litigation in the course of their fulfillment of their duties. However the clause in Section 9A, entitled “Exemption from Liability” is too vague and in the context of the recent allegations of financial impropriety leaves too many loopholes for fiduciary dereliction going forward. As such we have suggested the inclusion of a comprehensive section detailing basic, good corporate governance. It is plausible that as a Statutory Body, we fall under Schedule 2 of the Statutory authorities act, which offers a cursory mandate for regular audit. However we believe that the precepts of corporate governance should be elaborated in our

Act to ensure the Council has clear guidance in meeting its mandate. Summarily, in our model Proposed Amendments to the Act we have included the following sections for Fiduciary Duty: Duty

of Care, Duty of Loyalty, Transparency and Disclosure, Accountability, a mandate for Annual Independent Audits and a budget. The Board, over successive conservative administrations, has

accumulated a considerable fund entirely derived from its Membership. Given this fact, it is unacceptable that the GMCSI team's primary focus regarding the Board's financial matters was on

fee collection, while failing to recognize the urgent need for an annual financial audit or a budget.

In section 6(2) the transparency of committees should be enhanced, with proposed clauses mandating the internal publication of the names of committee members, as well as the minutes and

reports of these meetings. There is no justification for concealment of these crucial details, and the composition and output of committees are relevant to ensure that these committees are

appropriately filled, representative, efficient and effective.

The proposed General Manager’s portfolio should be restricted to administrative work and this post removed from the Council, ensuring that he/she is not involved in executive functions e.g. the signing of cheques, or directly liaising with external stakeholders and ministries parallel to the President and Secretary. It is crucial that this officer who is being granted indefinite

terms, never supplants the role of the elected council.

In lieu of a GM on council we suggest the inclusion of a Certified Internal Auditor, appointed by a relevant regulatory body. The internal auditors role will be deeper and more involved than an accountant; ensuring that all corporate processes; administrative, contractual, hiring and purchasing are relevant, transparent and optimized. This appointment can provide the Fiduciary oversight and reassurance necessary during the expansion of the Boards services and assets. They can also assist in the External Audit and the preparation of a budget.

We assert that the appointees on Council have a duty to protect both the interest of the public and the Membership of the Board. As such the lawyer, accountant and proposed auditor should seek to ensure that the council is always in compliance with the precepts of good corporate governance and the provisions of our Act.

Contrary to the GMCSI's advice, the Medical Council should not seek independence from the Board's Membership. Instead, the Board and its Council as a whole should strive to insulate themselves from external influences, whether political, corporate, or from potentially compromised health governance agencies (such as the WHO, which has increasingly succumbed to pharmaceutical lobbying). The Board should be confident that in policy matters or deliberations susceptible to undue political pressure, the Council possesses the resilience and autonomy to vote against politicians and bureaucrats when necessary.

To achieve this, the Council should primarily consist of elected members who are:

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1. Chosen to serve the interests of the Profession
2. Actively engaged in the Board's work
3. Subject to recall if they fail in their duties

We propose that for future councils, the two physicians currently appointed under ministerial

discretion should instead be elected by the Board, resulting in a total of six elected, working physicians on the Council. Given the Board's increasing workload, consideration should be given to expanding this number to seven or eight elected members.

Lastly, Regarding the need to strengthen patient protection against malpractice, Continuing Medical Education (CMEs) alone is inadequate. Both the Ministry of Health JSC report and the GMCSI report failed to address a critical need for bioethics provisions in law. This deficiency, while common in medical legislation worldwide, is nonetheless significant and urgent.

In light of the COVID-19 public health crisis, the medical fraternity should be cautious of any top-down, bureaucratic medical regulation as promoted by the GMCSI. An analogous approach to public health governance led to a series of irrational, injudicious, unempirical, and potentially dangerous health policies which have had long term deleterious effects on the population,(for example the protracted closure of schools, targeted marketing of inadequately tested vaccines for children and teenagers, systemic medical segregation, and unjustifiable denial of funeral rites) These might have been mitigated had there been adequate bioethics provisions in law which safeguarded patient rights.

A Proposed Bioethics Amendment to section 24 includes provisions for:

1. Voluntary Informed Consent
2. Proportionality of Risk and Benefit
3. Minimization of Risk and Harm
4. Rational-Evidence Based Practice
5. Right to Refuse or Withdraw
6. Integrity in Communications
7. Right to Non-Discriminatory Care

To support these provisions, two key concepts were introduced in Section 2:

1. Medical Intervention
2. Compos mentis (of sound mind)

This comprehensive section aims to protect both doctors and patients from potential harm and embarrassment. It provides clear guidance for medical practitioners, when performing high-risk procedures, administering novel medical interventions or conditions for referral. Patients should benefit from clinical practice that is better documented, more judicious, transparent,

better communicated, and more respectful of patient autonomy. In public health matters, policy

measures in abidance with these provisions must be measured, risk-averse, transparent, and accurately communicated.

These Bioethics provisions, derived from the Helsinki Declaration, the Nuremberg Code and the Patient Charter of rights, offer concrete legislative solutions for enhancing patient safety and preserving patient rights. They are intended to replace non-statutory codes, which require interpretation in medical negligence cases. We propose that these amendments are inserted into

Section 24 of the Act which deals with discipline, however subject to further discussion they may take form in a separate Regulation. Notably, these clauses are not commissioned by any political directorate, university, or clinical governance agency like the WHO. Instead, they are generated by physicians in practice who have recognized an urgent need for such provisions and

are thus presented to the Board though an initiative in self-governance.

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The GMCSI report, which advised restructuring the Council within the confines of the legislative framework, fails to appreciate the fundamental value of the Acts self-governing tenets. Based on

a limited tele-survey of just 10 persons (8 council members and 2 from the secretariat), it recommended that in the interest of modernizing the Board, the Executive Committee should explicitly agree that its

"purpose of regulating medical doctors is to protect patients, and not, to represent medical doctors."

This simplistic view, derived from such a limited exercise, not only jeopardizes the integrity of our self-governing structure and but ignores the Council's statutory obligation to doctors.

In reality, our mandate is far more comprehensive. The Medical Board, its Council, and its Membership have a duty to protect and uplift not only the public but also our Boards service to the Fraternity itself. As as such the expansion of our Medical Board's services and functions

must be guided by modernized legislation that strengthens both our corporate and ethics governance structures. This evolution also demands enhanced transparency in the actions of the Council and the management of our funds

Ultimately, the Board can only fulfill this multifaceted mandate through respectful, earnest dialogue with our membership. Today's meeting demonstrates the strength of this self-governance, which is essential in shaping legislative reforms that ultimately benefit the public by elevating the standards of our profession. The integrity of clinical practice in our country and the overall health of our public benefits from the collective wisdom, experience, and ethical standards inherent in the Membership of the Board. Therefore, as we move forward with the modernization of our Act and the expansion of the MBTT, it is crucial that the Council consistently and respectfully consults with the Members of the Board, earnestly seeking to obtain and represent their position.

In deference to this principle we ask that our committees collaborate to produce a comprehensive legislative package that is sensitive to the discussions and feedback generated by this SGM's referendum. We then call for a follow up in 3-6 months wherein the general membership is presented with the legislative package for further debate and approval. I suggest that we agree on the date of this follow up SGM before close.