From: GMC Services International
Date: 9 December 2021

STRUCTURAL REVIEW OF THE EXECUTIVE COUNCIL OF THE MEDICAL BOARD OF TRINIDAD & TOBAGO

Programme Director: Helen Featherstone
Subject Matter Expert: Paul Buckley

GMCSI Ltd is a trading subsidiary of the GMC, company no. 1053 0157

A good organizational structure assists greatly in the survival, continuity and stability of an organization. According to Peter Drucker, "the wrong structure will seriously impair performance and may even result in the destruction of the organisation. Organisational structure must be designed in a way in which it can achieve its objectives in the short-, medium- and longer-term. It should be designed in a way to clarify who does what, who is responsible for what and to remove obstacles to performance. Organisational structure should furnish decision-making and be designed to ensure good communication networks which support the organisation's objectives".

The seven principles for organisational effectiveness:

- *Be mission driven*
  - *Align team members to focus on a vision or mission*
- *Be effective, not efficient*
  - *Do the right things (effective), don't focus on doing things right (efficient)*
- *Put your best people on your best opportunities.*
  - *Have the best people to do the right things*
- *Focus on opportunities, not problems*
  - *Put energies where the results are*
- *Know the power of "planned abandonment"*
  - *Focus on what you are good at, don't try to do everything*
- *Focus on the Customer*
  - *An organisation runs for the benefit of its outsiders, not insiders*
- *What gets measured, gets managed*
  - *The right things will not be done without some form of measurement*

By Peter Drucker, an influential writer on the subject of management theory and practice.

Table of Contents

1 Executive Summary

1.1 Introduction

1.1.1 In October 2021, General Medical Council's (GMC) subsidiary GMC Services International Limited (GMCSI) was contracted by the Medical Board of Trinidad and Tobago (MBTT) to carry out a review of the structure of its Executive Council (EC). The specific objective was summarised in this way:

'The Trinidad and Tobago Medical Board would like the current structure of their Executive Council reviewed with suggestions made in terms of how to make the overall functioning of the Council more effective.'

1.1.2 The review was conducted by GMCSI between October and December 2021. This report presents the findings of the review and includes recommendations aimed at supporting the modernisation of the EC, albeit within the limitations of the statutory framework it currently operates under.

1.1.3 The review was conducted in four phases that involved a series of virtual meetings with EC members, staff and wider stakeholders in Trinidad and Tobago, together with supporting work in the UK.

1.1.4 Phase 1 involved an initial scoping of the work and included planning sessions with the Secretary of the EC and a review of material available on the MBTT's website in order to understand the status quo.

1.1.5 Phase 2 followed and involved a detailed information gathering exercise and individual interviews online with EC and staff members and senior members of the medical profession in Trinidad and Tobago. A list of the members, stakeholders and staff interviewed as part of Phase 2 is at Annex 1.

1.1.6 Phase 3 involved firming up the key areas on which to make recommendations, developing and drafting the report, sense-checking it with a representative of the EC and making changes in the light of feedback received.

1.1.7 Phase 4 concluded with the presentation of this report to the EC, making further changes and submitting the final report.

1.1.8 The recommendations in this report have been graded according to the following table.

Importance	Meaning
Essential (E)	Without implementation of this recommendation, the EC will be unable to make the progress necessary towards greater efficiency and effectiveness.
Highly desirable (HD)	Implementation is required to address key areas of weakness
Desirable (D)	Implementation required for best practice regulation

1.2 Background

1.2.1 The Medical Board of Trinidad and Tobago (MBTT) was proclaimed by Governor Woodford in 1814. In its modern form, the Board's structure and functions are set out in The Medical Board Act of 1960 (as amended).

1.2.2 Until 2007, when the Act was amended, the majority of members on the EC were medical doctors elected by the MBTT as a whole. The EC now consists of eleven members, and elected members are in a minority. The EC elects its President, Vice-President, Secretary and Treasurer. All must be medical doctors. Members serve a three-year term, with an option to renew.

1.2.3 Four administrative staff support the Executive Council.

1.2.4 The proposal agreed between GMCSI and the EC was to carry out a Strategic Review of the current structure of the EC. This would include a review of the structure as it currently stands, bearing in mind the challenges highlighted below:

a) The physical structure of the EC, for example, should there be a Chief Executive Officer (CEO) and/or a Chief Operating Officer (COO), the potential role for a legal officer and possibly expanding the number of administrative staff

b) Structuring the EC to improve services provided to the MBTT

c) The way in which to structure to address challenges caused by the medical register and specialist register which end up in litigation

d) Inclusion of non-medical practitioners in the EC

e) The perception that they are an Association and not a Medical Board resulting in a lack of support by medical doctors who are all Board members

f) Lack of necessary powers due to the outdated Medical Act of 1960

1.3 Findings

1.3.1 Based on the interviews we conducted, the organisation is seen as old-fashioned in approach, slow in dealing with issues referred to it, and poor at communicating with the profession and others. To its great credit the EC itself fully recognises this picture and EC members were as, or even more, frustrated than others with its performance. It is clear that much of the current difficulty lies in the out-of-date statutory framework (which is to be the subject of a separate review) but also the EC's current reliance on unpaid, volunteer EC members working at most one day a week to undertake functions which really require permanent, senior executive oversight to deliver them effectively.

1.4 Conclusions

1.4.1 The MBTT and the EC are, like the vast majority of regulators, creatures of statute. The EC has identified the need fundamentally to modernise the 1960 Medical Act. In the meantime, and without any change to the underpinning legislation, there is a great deal that can be done to improve the functioning of the EC and set it on the road to being a modern, effective and efficient medical regulator.

1.5 Summary of Recommendations

Recommendations, with priorities, are provided throughout this report in the context of the relevant findings. They are as follows:

Recommendation 1: *The EC should develop and publish a clear statement of its core purpose as the regulator of the medical profession of Trinidad and Tobago and should seek its incorporation into an amended Medical Board Act at the first opportunity. (E)*

Recommendation 2: *The EC should incorporate the purpose statement into role descriptions for each member, setting out the duties of and expectations of*

each member with particular emphasis on the core purpose of public protection. (E)

Recommendation 3: *The EC should develop and publish a clear policy on payment of expenses necessarily incurred by members on Council business. (HD)*

Recommendation 4: *The EC should immediately develop a role description for a new COO role, and recruit for it as quickly as possible. (E)*

Recommendation 5: *The possibility of reintroducing a complaints screening function should be explored in order to reduce the overlap between the functions of investigation and adjudication, and to improve the speed and efficiency of handling complaints. (HD)*

Recommendation 6: *The EC should undertake a cost/benefit analysis of the merits of establishing an in-house legal advisor role. (HD)*

Recommendation 7: *The EC should establish a new digital communications officer role to enable a step change in communications with doctors especially, to improve the website and to move the medical register fully online. (HD)*

Recommendation 8: *Three new full-time roles be created to meet the challenges faced by a lack of resources, as outlined in this report. Having the additional resources will ensure greater efficiency, a stronger delivery of the five-pillar strategy, possibly lower litigation costs and a more defined complaints handing process and a better relationship with the members through the use of digital communication, to mention a few. (E)*

Recommendation 9: *When an opportunity arises to amend the 1960 Medical Act, it would be helpful to consider amending the provision under which medical doctors are referred to as members of the MBTT and to make clear they are registrants of it. (D)*

Recommendation 10: *The function of suitably investing financial reserves and maximizing returns on investment should be delegated to the Treasurer. The Treasurer should also be analysing the financial impact of the five-pillar strategy on these reserves and working closely with the COO to manage cash flow efficiently throughout the delivery of the organisational strategy. This should be clearly differentiated from the role of Accountant to avoid confusion. (D)*

Recommendation 11: *The Medical Act should be updated to allow for the EC to develop a suitable process for debt collection. Should a medical doctor not make payment once all the agreed debt collection steps have been taken, the medical doctor should have their registration removed. (HD)*

Recommendation 12: *The digital communications officer's role is to include the development of an online register of medical doctors. Having an online register will remove the cost of publishing the register in the Gazette, provide easy access for those wishing to view the register and hold an up-to-date medical doctor database for the regulator. This will enable the EC to analyse medical doctor pathways, conduct surveys and have knowledge of which medical doctors have paid their ARF. (HD)*

Recommendation 13: *Develop a consistent approach and process for the handling of complaints and publish this on the website. This will allow for full transparency and will build trust amongst the registrant base. (E)*

Recommendation 14: *The EC should establish a training programme for new and existing members who adjudicate on disciplinary cases. (E)*

Recommendation 15: *The training programme should include written materials to support fair, consistent and proportionate decisions, and those materials should be published. (HD)*

Recommendation 16: *The EC should develop an orientation/induction programme for new members so that they are contribute fully as soon as possible within their tenure. This should include any necessary Information Technology (IT) support. Members should also be provided with a business email address by the EC for official communications they undertake in their capacity as EC members. (A separate recommendation is made above about training to sit on disciplinary cases and the writing of job descriptions to clearly outline the requirements of the different positions.) (HD)*

Recommendation 17: *The EC should develop a CME policy in line with the guidance from IAMRA, and in the longer-term should consider the possibility of linking continued registration with evidence that the doctor is undertaking suitable CME and keeping up to date (HD).*

Recommendation 18: *The new COO should develop a detailed, prioritised plan for delivering the five pillars programme and agree it with the EC. (E)*

Recommendation 19: *The EC should apply to be members of IAMRA (D).*

In summary, of the 19 recommendations, 7 are regarded as (E) Essential, 9 as (HD) Highly desirable and 3 as (D) Desirable.

2 Introduction

2.1.1 In October 2021, General Medical Council's (GMC) subsidiary GMC Services International Limited (GMCSI) was contracted by the Medical Board of Trinidad and Tobago (MBTT) to carry out a review of the structure of its Executive Council (EC). The specific objective was described in this way:

'The Trinidad and Tobago Medical Board would like the current structure of their Executive Council reviewed with suggestions made in terms of how to make the overall functioning of the Council more effective.'

2.1.2 The review was conducted by GMCSI between October and December 2021. No site visits were made because of the ongoing Covid pandemic and for reasons of economy and efficiency. This report presents the findings of the review and includes recommendations aimed at supporting the modernisation of the EC, albeit within the limitations of the statutory framework it currently operates under.

2.1.3 The review was conducted in four phases that involved a series of virtual meetings with EC members, staff and wider stakeholders in Trinidad and Tobago, together with supporting work in the UK. The GMCSI team compromised a subject matter expert – a former Director of Strategy and Policy of the GMC with 25 years' experience in medical regulation – and the GMCSI's Business Manager.

2.1.4 Phase 1 involved an initial scoping of the work and included planning sessions with the Secretary of the EC and a review of material available on the MBTT's website in order to understand the status quo. At the end of Phase 1 a Project Initiation Document (PID) was developed to confirm the scope and objectives of the work, plan the remainder of the review and ensure focus on the priority areas.

2.1.5 Phase 2 followed and involved a detailed information gathering exercise during which the GMCSI's subject matter expert and Business Manager identified and gathered key documentation, conducted individual interviews online with more than half the members of the current EC, some members of staff and a number of senior members of the medical profession in Trinidad and Tobago who were in a position to comment on the performance of the EC. A list of those interviewed as part of Phase 2 is at Annex 1. Further documentation was also obtained and reviewed at this stage, and possible areas for recommendations were tested as discussions progressed.

2.1.6 Phase 3 involved firming up the key areas on which to make recommendations, developing and drafting the report, sense-checking it with a representative of the EC and making changes in the light of feedback received.

2.1.7 Phase 4 concluded with the presentation of this report to the EC, making further changes and submitting the final report.

2.1.8 The recommendations in this report have been graded according to the following table.

Importance	**Meaning**
Essential (E)	Without implementation of this recommendation, the EC will be unable to make the progress necessary towards greater efficiency and effectiveness.
Highly desirable (HD)	Implementation is required to address key areas of weakness
Desirable (D)	Implementation required for best practice regulation

3 Background

3.1.1 The Medical Board of Trinidad and Tobago (MBTT) was proclaimed by Governor Woodford in 1814 (almost half a century before the General Medical Council of the UK was established). In its modern form, the Board's structure and functions are set out in The Medical Board Act of 1960 (as amended). A key feature of the structure is that all doctors who obtain registration in Trinidad and Tobago are automatically 'members' of the MBTT. The Executive Council (EC) is described in the Act as a 'Council of the Board'; it is, thus, a sub-set of the medical profession in Trinidad and Tobago but (especially since 2007) with additional non-medical members.

3.1.2 Until 2007, when the Medical Act was amended, the majority of members on the EC were doctors elected by the MBTT as a whole. The EC now consists of eleven members, and elected members are now in a minority. The full composition of the EC is:

a) Two medical practitioners appointed by the Ministry of Health

b) Four medical practitioners elected by Board members

c) One medical practitioner nominated by the University of the West Indies

d) A Chief Medical Officer (ex-officio)

e) A legal representative (attorney) with five years' experience. The attorney is nominated by the Law Society of Trinidad and Tobago

f) With five years' experience, a chartered accountant nominated by the Association of Chartered Accountants

g) One person nominated by the Inter-Religious Organisation.

3.1.3 The EC elects its President, Vice-President, Secretary and Treasurer. All must be medical doctors. It meets on a monthly basis (although more recently has been meeting more frequently in order to deal with the volume of work). Members serve a three-year term, with an option to renew. There is currently no limit on the number of terms a member may serve and some of the current EC have served for three terms or more. Out of the eleven members of the EC, three members' terms of office end each year, thereby ensuring a balance of continuity and turn-over. All EC members work on a pro-bono basis and have busy professional lives outside of their EC roles. Members do not claim expenses individually.

3.1.4 The powers of the EC are as follows:

- for the good governance of the MBTT and for the proper conduct of its affairs;

- for regulating the time, manner and place of meetings of the MBTT and the EC and the proceedings thereof;
- for the conduct of elections including the manner of voting thereat, and all other matters arising out of or incidental to the elections as provided for in the Medical Act;
- with respect to the fees for registration or for the issue of a temporary licence and the amount of any annual or special fees to be paid by members;
- with respect to the determination of the professional qualification and experience including internship required of an applicant for registration or for a temporary licence, and for proof of professional conduct and general fitness to practise in medicine;
- for regulating the manner of applying and using the funds of the MBTT;
- for prescribing anything required or authorized to be prescribed;
- for prescribing in respect of any contravention thereof or failure to comply therewith a penalty not exceeding a fine or three hundred dollars or imprisonment for three months on summary conviction.
- no rule or regulation shall come into force or have effect until it has been approved by the Minister.

3.1.5 The Medical Act specifies some matters which pertain to the MBTT (as distinct from the EC). The key ones are:

a) for there to be an Annual General Meeting for Board members (ie for all doctors)
b) To receive the accounts and a report of the EC's work at that meeting.

3.1.6 The proposal agreed between GMCSI and the MBTT was to carry out a Strategic Review of the structure of the EC. This would include a review of the structure as it currently stands, bearing in mind the thoughts and comments mentioned below:

a) The physical structure of the EC, for example, possibly including a Chief Executive Officer (CEO) and/or a Chief Operating Officer (COO), the potential role for a legal officer and possibly expanding the number of administrative staff
b) Structuring the EC to improve services provided to the MBTT
c) The way in which to structure to address challenges caused by the medical register and specialist register which end up in litigation
d) The inclusion of non-medical doctors in the EC
e) The perception that they are an Association and not a Medical Board resulting in a lack of support by medical practitioners who are all Board members
f) Lack of necessary powers due to the outdated Medical Act of 1960

3.1.8 According to data provided to GMCSI, by the end of 2020, the EC was regulating approximately 6,300 doctors. It now processes around ten to twelve complaints a month, of which one or two are referred to a public hearing. (This pattern is not unusual in regulatory proceedings as the threshold for action is, rightly, a high one. It is important that complaints that are less serious, but which still have merit are referred to the employer, where appropriate, to consider).

3.1.9 The review was conducted during October and December 2021. This report presents the findings of the review and includes recommendations graded in three tiers according to their priority: Essential, Highly Desirable, and Desirable.

4 The purpose of modern professional medical regulation

4.1 As organisational purpose has a strong influence on organisational structure, it is useful to examine this more closely with respect to the MBTT.

4.2 There is widespread agreement across the world that the purpose of regulating medical doctors is to protect patients, and not, for example, to represent medical doctors. The particular form that regulatory bodies take may vary, depending on local circumstances. The International Association of Medical Regulatory Authorities (IAMRA), a global body which consists of more than 100 regulatory organisations, has said: 'Even within IAMRA's membership, a number of different models of regulation are represented. …IAMRA does not promote a particular model of medical regulation, recognising that models are influenced by the structure of the healthcare system, the legal framework in which regulatory authorities operate and the resources available'.

4.3 All regulators face some similar challenges including the need to act, and being seen to act, independently, while retaining very close links with medical doctors, government, the healthcare system in which they operate, and the patients and public whose interests they serve. A series of medical scandals in a number of different countries over the past 25 years has resulted in an observable evolution away from 'pure' models of self-regulation in which medical doctors literally regulated themselves, to one which includes a broader range of perspectives including the public and providers of healthcare. In Trinidad and Tobago, the composition of the EC was amended in 2007 such that elected medical doctors were no longer in the majority, and a number of non-medical public members were introduced. In all the discussions it was suggested that this development was helpful and necessary.

4.4 In the past, it was often not thought necessary to say explicitly what the purpose of a regulator was. It was rather taken for granted by everyone that in carrying out their functions, in whatever sphere, they were doing so in order to protect the public. The Medical Board Act of 1960, for example, does not explicitly say that the purpose of the EC is to protect the public: it sets out the functions that the EC must discharge from which the public protection role can be inferred. However, many regulators have

nowadays found it useful to be absolutely explicit about their purpose, especially when the fairness or independence of the decisions they make comes under scrutiny or even attack.

4.5 During the course of the review, GMCSI were made aware of the case of *Bernard Mohamdally vs the Medical Board of Trinidad and Tobago* (CV 2007-01802). The key issue in that case, which does not directly concern us here, was whether in exercising its disciplinary functions (although the reasoning applies to all its functions) the MBTT was a 'public authority' for the purposes of a freedom of information request. In her judgment, Madame Justice Dean-Armorer commented that 'any analysis must necessarily begin with the inescapable premise that the Medical Board is an independent body in so far as it is not answerable to any Minister of Government, save in its rule-making functions…..The Court must however consider whether it exercises its disciplinary functions on behalf of the people of the Republic of Trinidad and Tobago, or whether the disciplinary functions are exercised only for the benefit of the body of registered medical practitioners' .

4.6 The learned judge noted that the EC derives its power from an Act of Parliament, distinguishing it from a body such as a trade union which derives their authority from the agreement of their members. She also observed that the offences listed in Schedule (S) 24 of the Act are all offences against patients and members of the public. On that basis, taking a permissive and purposive view of the 1960 Medical Act, she concluded 'it would be clear that the disciplinary power of the Council has been conferred by Parliament for the protection of the public. The disciplinary function is, therefore, exercised on behalf of or for the benefit of the population at large and under a permissive interpretation on behalf of the people of Trinidad and Tobago'.

4.7 The learned judge helpfully articulated here the fundamental principles of a modern professional regulator: its powers are conferred by Parliament, but its decisions are made independently of Government. It acts to promote the interests of patients and the public, not the interests of medical professionals.

4.8 This background suggests that it would be very useful if these key points about the core purpose of the EC were to be enshrined in the Medical Act itself, when it is amended in the future, to avoid them having to be inferred.

4.9 In the meantime, there would be significant benefit if the EC, as a matter of policy, developed a statement of its purpose, making clear it is to regulate the medical profession independently to protect the public by upholding high standards of medical professionalism and practice. The absence of such a statement currently is a significant deficit. This is all the more glaring a gap given that modern regulatory practice goes much further than delivering functions efficiently, as envisaged in the 1960 Medical Act, important as that is.

4.10 Most regulators now focus on 'moving upstream', that is, pro-actively promoting good standards of practice and education to all members of the profession rather than intervening on a largely reactive basis to discipline doctors after a patient has suffered harm. Apart from being a more positive and ultimately effective model of regulation, it makes it easier to justify to the profession whose fees are funding the costs of regulation what its purpose is.

Recommendation 1: *The EC should develop and publish a clear statement of its core purpose as regulator of the medical profession of Trinidad and Tobago and should seek its incorporation into an amended Medical Board Act at the first opportunity. (E)*

5 The Role of EC Members

5.1 There are currently no role descriptions for EC members setting out the contributions expected from members, and clear expectations in terms of, for example, declaring and managing any conflicts of interest.

5.2 Members come from different perspectives and that is a significant strength of the current arrangements. The EC benefits from having a mix of members, some elected by medical doctors, some appointed by Government and others nominated by other professions or public bodies. Regardless of how they have joined the EC, they must leave that allegiance 'at the door'. For example, the nominee from the University of the West Indies, the Law Association, the Chartered Accountants or the Inter-religious Organisation or of the Ministry of Health, is not a delegate or representative of that organisation. He or she will, of course, be aware of what its views are likely to be on the various policy questions the EC deals with, but it is his or her own, independent judgment of what is required in the public interest that the EC needs in its deliberations.

5.3 By the same token, it is really important, in fact it is essential, that the EC understands what the perspectives of medical doctors generally are, and the elected medical members can contribute to that insight. Elected members, like their colleagues, are first and foremost EC members and their primary purpose is, like their colleagues, to protect patients. They can and will *reflect* the views of medical doctors, but, although elected, they are not there to *represent* them. Within Trinidad and Tobago that is the role of a representative membership body such as the TTMA.

Recommendation 2: *The EC should incorporate the purpose statement into role descriptions for each member, setting out the duties of and expectations on each member with particular emphasis on the core purpose of public protection. The EC should also consider whether there should be a maximum time limit for service on the EC. (E)*

5.4 A related issue which goes to perceptions of regulatory independence is under S4 of the 1960 Act, all medical doctors registered with the MBTT have the status of 'members' of the MBTT. Thus, the regulatory body in reality, the EC, is in strict legal terms a constituent part of a larger medical membership body rather than an entity in its own right. It is the MBTT which is formally the organisation which takes or is subject to legal proceedings. S6 of the 1960 Medical Act underlines this relationship.

5.5 The 1960 Medical Act provides that the MBTT must hold an Annual General Meeting (AGM) each year at which the EC reports on its work and presents its accounts to the members. The AGMs are poorly attended, and non-medical members of the EC may see it as a meeting relevant only to medical doctors.

5.6 There is a real risk here of a perception that the EC is an adjunct of the medical profession, and so in some way subject to the wishes of its members, those medical doctors are registered with it. This model would fit if the context were a commercial Board's relationship with its shareholders, or a charity's 'Trustees' relationships with its members. However, as the learned judge pointed out so clearly in the case of *Mohamadally*, the EC is a regulatory body and not a membership body.

5.7 In our view it may be helpful, in order to bolster perceptions of the independence of the MBTT, and to avoid any possible confusion with the membership body proper, (the Trinidad and Tobago Medical Association (TTMA)), to seek an amendment to the 1960 Medical Act such that doctors are referred to as 'registrants' rather than 'members'. In this way, the future MBTT would be visually distinct from the profession which they regulate, which is in the public's interest.

5.8 We acknowledge that this is a matter of appearance rather than substance, but in the world of regulation, perception is itself very important in fostering external confidence. The change in terminology from 'member' to 'registrant' would in no way impede medical doctors from doing certain things under the Medical Act that they currently do, for example, electing members of the EC. Nor would it prevent the MBTT from holding an AGM, but such an event if held should be for all those with an interest in the operation of the MBTT, not just the medical profession, especially as we heard that even some non-medical members of the EC do not attend AGMs of the MBTT as they are seen to be events of interests only to medical doctors.

5.9 It has previously been pointed out how reliant the EC is on the purely voluntary and selfless service of its members. (Regulation 17 provides for the Secretary-Treasurer to receive an Annual Honorarium of $500 T&T, ~$75 US dollars but the actual amount paid is TT$9,000 or ~$1,350 US dollars, as approved at an AGM). The time commitment for EC members has increased and it is clear this is not sustainable. In the next section we propose how this might be addressed structurally. Here we note that, apart from the very modest honorarium payable to the Secretary-Treasurer, the legislation makes no explicit provision for members' expenses (such as fuel costs for travelling to meetings) to be reimbursed. (S35 makes reference to payment 'of all expenses incurred in carrying out the provisions of this Act' but that seems to relate to the costs of the organisation generally, not individuals' expenses).

5.10 We are not in a position to comment on whether, in the context of public service in Trinidad and Tobago, it would be seen as reasonable for all EC members to receive an honorarium. That is an issue that should be explored when the 1960 Medical Act is amended. In the meantime, it is not good practice for EC members to have to incur expenses on legitimate and necessary EC business for which they cannot be reimbursed. We therefore recommend that the EC should urgently address this issue and develop and publish a clear expenses policy based on the practice of comparable organisations in the country.

Recommendation 3: *The EC should develop and publish a clear policy on payment of expenses necessarily incurred by members on Council business. (HD)*

6 A Review of the Organisational Structure of the EC

6.1 General

6.1.1 The EC is a small organisation with just four permanent staff supporting it in regulating over 6,300 practitioners. Two staff members undertake largely administrative functions and carry out some operational registration work, and there is also a data entry clerk and a messenger/cleaner.

6.1.2 It is clear that a significant amount of experience and corporate memory resides within the administrative team, some of whom have served the MBTT and EC for many years. However, much of the information held by the team is not formally documented and there is no recognisable data-management system. In the event that one or two members of staff left suddenly, the EC would struggle to function.

6.1.3 An additional feature of this current structure is the firm demarcation line between the administrative staff and the EC members, to the extent that in recent years none of the staff routinely attend EC meetings. Instead, the Secretary of the EC (ie, an EC member) makes notes of meetings which a staff member helps to turn into formal minutes outside of the meeting. It appears that this practice became entrenched some years ago when relationships between some EC members and the staff became severely strained. The practice has persisted even though relationships now were described as positive and constructive.

6.2 Identified Gaps within the Organisational Structure

Role of COO

6.2.1 There were a number of positions GMCSI was asked to consider, one of which was whether the EC should establish a new, senior executive post to be called either CEO or COO. There is no doubt that MBTT should establish such a post. There are several good reasons why, as outlined below.

6.2.2 First, it was repeatedly mentioned that the EC had struggled to deliver major projects (the Specialist Register was the prime example given) and a key reason was the dependence on EC members, who are part-time, to do all but the basic administrative components of a project. In addition, it is essential to address the functional disconnect between members and staff. A senior executive would be able to bridge that gap by attending EC meetings, and, working closely alongside EC members, provide advice as necessary, drawing on the knowledge and experience of all the staff team. Third, there are some specific capabilities which the EC needs to be able rely on to which it does not currently have access, including a senior executive able to:

6.2.2.1 lead the development of policy, and deliver major operational changes

6.2.2.2 commission and embed a modern data-management system to enable the efficient recording and retrieval of key information

6.2.2.3 draft important letters for the EC to consider and, on their own initiative, to enable correspondence on behalf of the EC to be dealt with more quickly and efficiently than at present between EC meetings, and

6.2.2.4 produce a detailed plan to deliver the five pillars strategy (Annex 3), to drive implementation of the plan and to report to the EC on progress.

6.2.3 It does not matter very much if the role is referred to as a COO or CEO, although based on the skills and requirements 'COO' feels more appropriate. What matters is to specify the right capabilities, to remunerate the role in accordance with its profile and high degree of responsibility, and to provide a direct reporting line to the President on behalf of the EC to ensure short lines of communication between executive and EC and to provide clear accountability.

6.2.4 That reporting line must not, however, lead to micro-management of the COO by the President as that would be self-defeating. The COO must be trusted to get on with their job and the role description must make clear that he or she will be expected to be able to operate with a high degree of autonomy within the general framework established by the EC.

6.2.5 It will be important that the successful candidate has a good understanding of the healthcare environment, an appreciation of medico/legal issues, experience of working in a statutory organisation and is a confident, sound decision-maker, and is inspiring, courageous and energetic.

Recommendation 4: *The EC should immediately develop a role description for a new COO role, and recruit for it as quickly as possible. (E)*

6.2.6 Over and above the role of COO, additional gaps within the organisational structure have been identified. What's more, the COO will require resources in order to deliver against the objectives mentioned above. These organisational gaps are highlighted under each of the headings below.

Supporting ongoing litigation challenges

6.2.7 The issue of having to handle an increasing number of complaints made about medical doctors and the rising costs of litigation were frequently brought to light. It is therefore important to examine whether improvements can be made to the way cases are dealt with, either through the existing process and structure, or by adding new resources, or both.

6.2.8 It is a well-established principle in legal or regulatory proceedings that the functions of investigating and adjudicating on complaints are, conceptually, distinct. In the case of the MBTT, the 1960 Medical Act vests both functions in the EC. In Godfrey Raj-Kumar and The Medical Board of Trinidad and Tobago (HCA No: 1048 of 2005) the Court of Appeal rejected a submission on behalf of the doctor concerned that it was biased for the EC to perform both functions. This was on the basis that the overlap of functions was provided for in the Act and that in in any case the existence of a right of appeal to the court against decisions of the EC 'saved the day'.

6.2.9 Nevertheless, although the current arrangements are lawful, they are clearly not optimal, and they do give rise to some practical and presentational challenges.

6.2.10 First, the legislative framework provides that the Secretary of the EC will communicate on its behalf, which inevitably introduces delay given that the Secretary, being part-time, is often unavailable and so correspondence must often wait.

6.2.11 Second, current practice is to share initial complaints with all members of the EC and the Secretary makes a recommendation on how the complaint should be handled. Involving the entire Council in this way is inevitably inefficient, but it also means that the overlap in investigatory and adjudicatory functions is built into the process from the very start. (In the long run, and provided the 1960 Medical Act can be amended, it would be desirable to look at the possibility of appointing non-EC members to investigate or adjudicate on cases in order to be able to deal efficiently with what is clearly a growing volume of work for just eleven (in practice ten as the CMO is ex officio) EC members.

6.2.12 A number of years ago the EC established the position of 'Special Investigator' whereby the Treasurer undertook initial screening of complaints, sought comments from the complainant and doctor and then made a summary recommendation to the EC. This meant the EC did not have to get involved with the details of the case and so were not in any way seen to be compromised if they subsequently needed to adjudicate on it.

6.2.13 Since that time, the relevant legislation has been amended and Regulation 7 of the Medical Board Regulations provides that 'all communications shall be directed through the Secretary-Treasurer'. It has been suggested that it may be possible for the initial letter acknowledging receipt of a complaint to be sent by the Secretary-Treasurer but for subsequent correspondence to be delegated to someone else, drawing on advice as necessary. We strongly recommend that the EC investigate this further, if necessary, taking legal advice. Rather than replicate the previous Special Investigator model exactly, it may be more helpful to use neutral language such as a 'Complaints Screener' and rather than place the weight on a single individual there would be merit in making clear that he or she should seek advice (which might be legal advice, or medical advice from another Executive Council member).

Recommendation 5: *The possibility of reintroducing a complaints screening function should be explored in order to reduce the overlap between the functions of investigation and adjudication, and to improve the speed and efficiency of handling complaints. (HD)*

6.2.14 The increase in the number of complaints has also resulted in a considerable and growing portion of the EC's funds being spent on legal fees arising from the handling disciplinary cases. An analysis of legal fees (most of which arose from handling complaints) indicated that the number of cases had increased in the period 2018-2020 and the costs had increased proportionately. Thus, in the nine years between 2012 and 2020, over half the legal costs were incurred in the most recent three years. Many interviewees expressed concerns about the rapid growth in legal spend, and one even described the costs position as being 'out of control'. There is a real danger that a vicious cycle could develop in which more and more resources are being consumed by a small number of cases, giving registrants the impression that the regulator is determined to pursue doctors almost regardless of cost, and at the same time reducing the funds available to spend on more productive activities.

6.2.15 The question was raised whether it would be more effective and economical to bring legal advice in house, rather than commission it externally. Some thought that the growing volume of legal correspondence alone could justify doing so. Against this, it was pointed out that at times there may be nothing for an in- house lawyer to be doing and it would be a waste of funds to be employing them. And so commissioning advice on an ad hoc basis, while expensive on the face of it, was overall better value for money.

6.2.16 This is a matter that needs careful analysis of the relative merits and costs. We recognise the force of the point that an in-house lawyer might at times not have enough to do, although bearing in mind that the EC will be seeking wholesale revision of the 1960 Medical Act, it is possible that if there was a lull in disciplinary activity from time to time (which does not seem at all likely), the volume of work associated with reforming the legislative scheme as a whole would make a source of in-house advice highly valuable.

6.2.17 In addition, a number of areas of the five pillars programme will require legal advice (eg securing accommodation) and some policy changes may do so as well (creating a functioning online register for example). Using an in-house lawyer would mean that the costs, including procurement, were fixed and known about prospectively and there would be no risk of perverse incentives to complicate matters rather than resolve them. (To be clear, we are not for one moment suggesting that outsourcing legal advice of itself entails such a risk, let alone that such a thing has happened. Rather, this is about addressing an unhelpful perception, which is undoubtedly well embedded already, that it does happen, filled by the length of time it is taking to resolve cases which is up to two years.)

6.2.18 If the upshot was that the EC decided to maintain the current outsourced arrangements, there would still be merit in considering moving to a retainer system (where the costs are subject to an agreed ceiling) rather than paying a fee for each individual item.

Recommendation 6: *The EC should undertake a cost/benefit analysis of the merits of establishing an in-house legal advisor role. (HD)*

Communication and digital technologies

6.2.19 A consistent theme in the discussions, with interviewees both inside the EC and outside it, was the urgent need to improve MBTT communications, especially with the profession but also with other stakeholders within the broader healthcare environment.

6.2.20 Feedback from senior doctors from outside the EC was that for most medical doctors there was virtually no engagement with the EC other than purely transactional exchanges in relation to payment of the ARF every year. While in theory all doctors can attend the AGM of the MBTT in practice very few (~20) ever do. Against the background of the pandemic, voting has for now been moved online and the numbers voting virtually are higher than when voting was in person. The proportion of voting online is believed to be in the region of 20%, but this is still small in proportion to the number of medical doctors registered and so entitled to vote.

6.2.21 Many doctors must ask themselves what they get for the ARF they are obliged to pay. Of course, some of the benefit of regulation is intangible but nevertheless very important. The maintenance of public confidence in doctors is hard to measure but is of immense value to every member of the profession. But even so, the EC should be asking what its 'offer' to registrants could be.

6.2.22 We are in no doubt that developing such an offer is a major opportunity to communicate with the profession. In the short term, this could involve, for example, publishing a regular digital newsletter with news about the work of the EC, and cautionary tales summarising recent tribunal cases (which in our experience are of immense interest to doctors and important too for medical students to be aware of as they begin on their careers). In the longer term, it should involve a shift to an 'upstream' regulatory approach. More about this in included in section 8 below.

6.2.23 Part of improving communications will be to improve the look and feel of the website, and to promote greater transparency in the work of the EC. It will also be to look at the additional elements which can be added in an interactive way, eg new or revised

policies and guidance being published, papers written on regulation to be shared with the profession and access to the medical register, to mention a few.

6.2.24 We were very struck by the fact that only a very rudimentary version of the register is available to view online (it lists names, but no qualifications or other data). It is necessary for a member of the public who wishes to view it in full (in hard copy) to pay a fee to do so (it is only $1 but is nevertheless a barrier) and request an appointment (an additional barrier). S19 of the Act requires that the MBTT publish the names of all medical doctors in the Gazette once a year. This is at a significant cost, some TT$10,000). When the Act is amended it will be imperative to remove that provision.

6.2.25 This model is significantly out of line with best practice in other countries, even including regulators without abundant resources. Regulators in countries as diverse as those in Australia or Zimbabwe publish their registers online, giving details of the name, qualifications, specialty and address or practice location of the doctor. (Other information, such as bank account details, date of birth etc are of course not public and are confidential between medical doctor and regulator). Not only does this service make the regulator visible and relevant to the public and employers of doctors, it also provides excellent data to the regulator which can be used for a range of regulatory purposes. For example, a register that included practice location would make it much easier for the EC to be confident which medical doctors were actually still practising in Trinidad and Tobago (some on the current register may have moved abroad or even be deceased, and there is no provision for the EC to remove someone from the register for non-payment of the ARF).

6.2.26 A digital, informative register would also enable the EC to improve its communications with doctors and undertake surveys of the profession for regulatory purposes such as to understand career intentions, investigate issues of stress and burnout and establish what kind of ethical dilemmas doctors are facing and need support with. (As well as surveying the profession, the EC could in time consider surveying the public, for example, to gather information about their experience of the professionalism of doctors and their expectations of them).

6.2.27 A digital register would also help with workforce planning, which is understood to be a challenging area because of a mismatch between an over-supply of recent graduates and an under-supply of specialists. A regulator able to model future supply and provide excellent data on the current state of the workforce is automatically more relevant to Government and the health services in its jurisdiction.

Recommendation 7: *The EC should establish a new digital communications officer role to enable a step change in communications with doctors especially, to improve the website and to move the medical register fully online. (HD)*

6.2.28 While we do not make a recommendation about this, the EC may wish to consider whether the non-medical members, but supported by one or more medical members, could pro-actively engage with patient and consumer groups in order to contribute the strongest public voice to its deliberations.

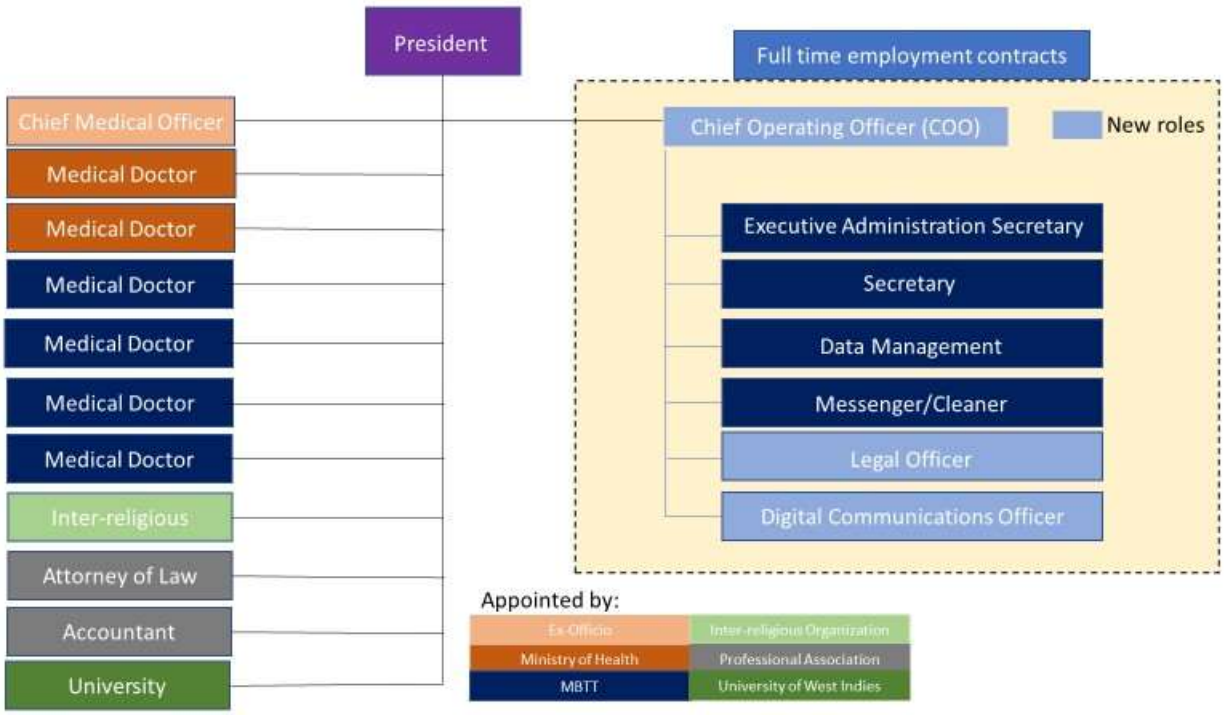
7 The Recommended Organisational Structure

7.1 Based on the findings highlighted in Section 6 above, it has been identified that further resources are required to support the EC in meeting its statutory function and to assist in the development and delivery of the five-pillar strategy.

Recommendation 8: *Three new full-time roles be created to meet the challenges faced by a lack of resources, as outlined in this report. Having the additional resources will ensure greater efficiency, a stronger delivery of the five-pillar strategy, possibly lower litigation costs and a more defined complaints handing process and a better relationship with the members through the use of digital communication, to mention a few. (E)*

7.2 Below is a recommended organisational chart highlighting these new roles. It is suggested that both the in-house Legal officer and Digital Communications Officer report to the COO. The COO reports to the President of the EC:

MBTT EC ORGANOGRAM



7.3 Each of these newly created roles (highlighted in the diagram above in light blue) will require detailed job descriptions with clearly defined roles and responsibilities. Examples of sample job descriptions for these roles can be found in Annex 5.

7.4 The job descriptions will require tweaking according to the specific requirements of the EC. Recommendations of what is to be included have been highlighted in the relevant sections of this report. To summarize, the COO should take responsibility for the five-pillar strategy, with support from six direct reports. This will need to be a person of reasonable seniority and with some understanding of the broader healthcare landscape, the medico-legal environment, and the general operational side of running an organisation. This role will also ensure that organizational memory is not lost when the EC transitions and new elected members join. The Legal Officer could be the initial point of contact for complaints and the 'complaints screener' mentioned earlier in the report. He or she could also assist with the writing of legal letters which may result in a decreased spend on external lawyers for this purpose (and procurement time to source these lawyers). The Legal Officer could also develop a complaints' handling process, to ensure consistency of approach and handling of these complaints as they are submitted and processed by the EC. This could potentially include sorting which complaints should be handled by the EC and which should be referred to the Regional Health Authorities (RHAs). The EC will still require public and/or criminal lawyers to appear in court. The Digital Communications Officer could write newsletters for

members and build and maintain a modern and engaging website, including an online medical register.

7.5 It is believed that such a structure would improve efficiencies and allow for suitable progress to be made across the five pillars, as well as the daily business operations of the MBTT. The COO's team's role will be to progress on the areas outlined in his/her job description, making recommendations to the EC on a regular basis (through the COO attending EC meetings). This will also free up the time of the EC members to focus more on making decisions to ensure progress, rather than remaining trapped in sorting through the detail.

8 Additional Points to Consider

This section covers some additional points that were raised which are out of the scope of this project (they may not be directly relevant to structural changes and a revised organisational chart), but it was felt it was necessary to include them in this report to paint a more holistic picture.

8.1 Differentiation of the MBTT

8.2.1 Concerns were raised regarding the independence of the MBTT and the differentiation of the MBTT from other "similar" organisations. In our view it may be helpful, in order to bolster perceptions of the independence of the MBTT, and to avoid any possible confusion with the membership body proper (the Trinidad and Tobago Medical Association (TTMA)) to seek an amendment to the 1960 Medical Act such that doctors are referred to as 'registrants' rather than 'members'. In this way, the future MBTT would be visually distinct from the profession which they regulate, which is in the public's interest.

8.2.2 We acknowledge that this is a matter of appearance rather than substance, but in the world of regulation, perception is itself very important in fostering external confidence. The change in terminology from 'member' to 'registrant' would in no way impede doctors from doing certain things under the Medical Act that they currently do, for example, electing members of the EC. Nor would it prevent the MBTT holding an AGM. Such an event, if held, should be for all those with an interest in the operation of the MBTT, not just the medical profession. It was highlighted that even some non-medical members of the EC do not attend AGMs as they are seen to be events of interests only to medical doctors.

Recommendation 9: *When an opportunity arises to amend the 1960 Medical Act, it would be helpful to consider amending the provision under which medical doctors are referred to as members of the MBTT and to make clear they are registrants of it. (D)*

8.2 Payment of the ARF

8.2.1 There is the question of the Annual Retention Fee (ARF), increases to which currently need to be agreed by the members. In order for the EC to be sustainable in the longer-term this dependence on getting agreement to fee increases, which is inevitably going to be very challenging, may need to be reduced, for example, by requiring the EC to

make its case for an increase to the members but with the ultimate decision resting with Government. Alternatively, the EC could have the power to decide itself, having taken soundings from its registrants and other stakeholders. We recognise that this will need much greater exploration and for now simply offer this comment without a firm recommendation.

8.2.2. We also observe, however, that the question of a ARF increase does not arise for the foreseeable future given the extensive financial reserves which the EC can draw on and because annual income comfortably exceeds expenditure. This puts the EC in a strong position to fund the additional posts and make the other infrastructure changes recommended in this report. Indeed, given that the majority of the reserves are merely held as cash on deposit, rather than invested, it would be beneficial for the EC to develop a prudent investment strategy (including the purchase of new accommodation) to maximise the return from reserves, especially given recent increases in inflation which will be eroding the value of its substantial cash deposits.

Recommendation 10: *The function of suitably investing financial reserves and maximizing returns on investment should be delegated to the Treasurer. The Treasurer should also be analysing the financial impact of the five-pillar strategy on these reserves and working closely with the COO to manage cash flow efficiently throughout the delivery of the organisational strategy. This should be clearly differentiated from the role of Accountant to avoid confusion. (D)*

8.2.3 There is no provision for the EC to remove someone from the register for non-payment of the ARF. Whilst penalties can be issued, the EC's hands are somewhat tied should a medical doctor refuse to pay.

Recommendation 11: *The Medical Act should be updated to allow for the EC to develop a suitable process for debt collection. Should a medical doctor not make payment once all the agreed debt collection steps have been taken, the medical doctor should have their registration removed. (HD)*

8.3 An online medical register

8.3.1 With the additional Digital Communications Officer resource, the current (and very rudimentary) register should be updated so that it can be viewed online (it currently lists names, but no qualifications or other data). It is necessary for a member of the public who wishes to view it in full to pay a £1 fee to do so. Whilst the price is not high, it is nevertheless a barrier, and an appointment must be made (a further barrier). S19 of the Act requires that the MBTT publish the names of all medical doctors in the Gazette once a year at significant cost (~TT$10,000).

8.3.2 The current register is significantly out of line with best practice in other countries, even including regulators without abundant resources. Regulators in countries as diverse as those in Australia or Zimbabwe publish their registers online, giving details of the name, qualifications, specialty and address or practice location of the doctor. (Other information, such as bank account details, date of birth etc are of course not public and are confidential between medical doctor and regulator). Not only does this service make the regulator visible and relevant to the public and employers of doctors, it also provides excellent data to the regulator which can be used for a range of regulatory purposes. For example, a register that included practice location would make it much easier for the EC to be confident which medical doctors were actually still practising in Trinidad and Tobago (some on the current register may have moved abroad or even be deceased, and there is no provision for the EC to remove someone from the register for non-payment of the ARF).

8.3.3 A digital, informative register would also enable the EC to improve its communications with doctors and undertake surveys of the profession for regulatory purposes such as to understand career intentions, investigate issues of stress and burnout and establish what kind of ethical dilemmas doctors are facing and need support with. (As well as surveying the profession, the EC could in time consider surveying the public, for example, to gather information about their experience of the professionalism of doctors and their expectations of them).

8.3.4 A digital register would also help with workforce planning, which is understood to be a challenging area because of a mismatch between an over-supply of recent graduates and an under-supply of specialists. A regulator able to model future supply and provide excellent data on the current state of the workforce is automatically more relevant to Government and the health services in its jurisdiction.

Recommendation 12: *The digital communications officer's role is to include the development of an online register of medical doctors. Having an online register will remove the cost of publishing the register in the Gazette, provide easy access for those wishing to view the register and hold an up-to-date medical doctor database for the regulator. This will enable the EC to analyse medical doctor pathways, conduct surveys and have knowledge of which medical doctors have paid their ARF. (HD)*

8.4 The Complaints Handling Process

8.4.1 According to data provided to GMCSI by the end of 2020, the EC was regulating approximately 6,300 doctors. It now processes around ten to twelve complaints a month, of which one or two are referred to a public hearing. (This pattern is not unusual in regulatory proceedings as the threshold for action is, rightly, a high one. It is

important that complaints that are less serious, but which still have merit are referred to the employer, where appropriate, to consider)

8.4.2 A key issue raised in virtually every meeting was the handling of disciplinary or fitness to practise cases. Many of the issues raised were about the language and provisions in the 1960 Medical Act, and they should be considered as part of a separate piece of work about how that legislation could be brought more up to date.

8.4.3 The complaints handling process was deemed to be inconsistent and feedback indicated that the complaints handling process was not clear and the process itself inconsistent. This led to a *mistrust* of the EC as there is no transparency in the process or the eventual outcome.

8.4.4 Another improvement to the handling of complaints which does not require legislative change would be to develop a training programme for EC members before they sit on tribunals. A number of members felt this was a desirable change which would enable cases to be dealt with more effectively and fairly. Such a training programme should involve drafting written materials to help guide decisions, for example, on thresholds for taking a case to a hearing, and on sanctions. In the interests of transparency, such materials should be published and would provide opportunities for the EC to raise the profile and importance of the work it does in protecting the public by setting and declaring clear standards of professional conduct. This is important in terms of reassuring medical doctors that where the EC takes action, it does so not to punish but to protect patients and maintain confidence in the profession. All medical doctors should understand the benefit, to them as professionals, of preventing unethical or incompetent colleagues from continuing to practise. But that message needs constant repetition and communication.

Recommendation 13: *Develop a consistent approach and process for the handling of complaints and publish this on the website. This will allow for full transparency and will build trust amongst the registrant base. (E)*

Recommendation 14: *The EC should establish a training programme for new and existing members who adjudicate on disciplinary cases. (E)*

Recommendation 15: *The training programme should include written materials to support fair, consistent and proportionate decisions, and those materials should be published. (HD)*

8.5 New EC member induction

8.5.1 It is understood that new EC members do not undergo any onboarding or induction-type training once they have been appointed to the EC. The elected members may be unsure of their exact role and what the role actually entails. EC members also mentioned using their personal email accounts for MBTT business matters.

Recommendation 16: *The EC should develop an orientation/induction programme for new members so that they are contribute fully as soon as possible within their tenure. This should include any necessary Information Technology (IT) support. Members should also be provided with a business email address by the EC for official communications they undertake in their capacity as EC members. (A separate recommendation is made above about training to sit on disciplinary cases and the writing of job descriptions to clearly outline the requirements of the different positions.)*

8.6 Continuous Medical Education (CME)

8.6.1 The question of CME, sometimes called Continuing Professional Development, CPD) was raised by many interviewees. One of the changes made to the 1960 Medical Act in 2007 was the inclusion of the following rule-making provision - S20 (1) (j): '..for establishing standards for continuous education and training of medical practitioners'. However, to date, no rules have been developed and there is thus no formal legal requirement on the part of doctors in Trinidad and Tobago to demo1nstrate that they are maintaining their knowledge and skills in a way that would give their patients confidence that their practice is up to date. The Physicians' Code of Conduct does say that doctors must 'keep their professional knowledge and skills up-to-date to ensure that the standard of care delivered to their patient ins maintained at the highest level'. But that statement is not underpinned by any further regulatory guidance or mechanisms to support doctors in doing so. (Over time, there is undoubtedly a major opportunity to fundamentally review the Code of Conduct and to invest much greater effort in promoting good ethic practice and conduct to the profession, and to medical students). The TTMA does, however, provide CME courses and opportunities and many doctors benefit from them.

8.6.2 IAMRA has had many discussions on the importance of doctors keeping up to date and has held conferences devoted to this topic alone, such is its importance. In October of 2021 IAMRA published a statement on continued competency which included this key summary:

'IAMRA supports and encourages medical regulators to develop and implement Continued Competency systems that are designed to improve patient safety and the quality of medical practice by promoting, encouraging or requiring career-long learning and continuous quality improvement for all practicing doctors. The model adopted should, as far as possible, be in accordance with the guidance in this statement. '

Recommendation 17: *The EC should develop a CME policy in line with the guidance from IAMRA, and in the longer-term should consider the possibility of linking continued registration with evidence that the doctor is undertaking suitable CME and keeping up to date (HD).*

9 Wider Strategy

9.1 Outreach/communications forms one strand of the EC's proposed areas of change 2021-2026, commonly referred to as the 'five pillars' (Annex 3). Five committees have been established to develop these core thematic areas, each headed by a EC member. Taken together, these five areas of work amount to a fundamental overhaul of the entire organisation, covering as they do accommodation, legislation, organisational structure, IT and outreach. This programme of work should also underpin a decisive move 'upstream' in terms of regulatory approach in which the focus of regulatory activity, and the allocation of resources, is on the promotion of good practice to the profession as a whole – rather than focussing so much resource and effort on a small number of misconduct cases, important though it is to deal with them quickly and fairly.

9.2 These five areas are absolutely the right ones for the EC to have identified (we are not in a position to offer detailed comment on the issues around accommodation although there was consistent feedback that the current arrangements are akin to 'squatting' and give an unprofessional impression of the organisation to visitors). We have touched on many of the other dimensions of the five pillars in this report, and they resonate strongly with what we were told and the views we have formed ourselves.

9.3 But the challenge now is to develop an integrated plan, with priorities, milestones, costs and risks clearly identified, to deliver the five pillars programme over the next five years. There is always a danger in these circumstances in trying to do too much all at once and ultimately doing a lot of things partially and badly. It may be sensible to address one or two 'burning platform' issues first, deliver change there, and go forward in the other areas. We would not underestimate the scale of the work programme here: to deliver it even incrementally will require constant direction, monitoring and reporting, together with adequate resources. The new COO would be ideally placed to lead on this, reporting direct to the EC.

Recommendation 18: *The new COO should develop a detailed, prioritised plan for delivering the five pillars programme and agree it with the EC. (E)*

10 International Engagement

10.1 Medicine is increasingly a global profession. There is a worldwide shortage of doctors and many in the profession are able and willing to move abroad and seek registration elsewhere. This is also seen Trinidad and Tobago. Analysis of registration data shows that there are medical doctors registered with the MBTT from no fewer than 79 different countries. A very large proportion (46%) qualified outside the country. (By way of a footnote, GMC data shows that over 150 doctors who qualified in Trinidad and Tobago hold a license to practise in the UK).

10.2 This pattern creates significant challenges for regulators in attempting to assess the skills and experience of applicants for registration who have migrated from another country, and to check their credentials. There are real issues around fitness to practise as medical doctors who have been disciplined in one jurisdiction may well seek to move to another without disclosing the issues that led to them being disciplined. (We are aware of one very high-profile case in Trinidad and Tobago along these lines).

10.3 In response to these challenges, a number of countries came together around 25 years ago with the intention of forming a pan-national organisation to facilitate information sharing and the spread of best practice in medical regulation. The organisation, IAMRA, now has over 100 members across five continents, and a very active programme of events and policy work. In the Caribbean region, a number of countries' regulators are already members of IAMRA, including the Bahamas Medical Council and the Medical Council of Jamaica. Being members of IAMRA would give the EC access to a large group of other regulators and enable benchmarking against best practice in key areas of strategic development (see for example, IAMRA's key principles for medical regulation at Annex 4). This will be invaluable as the EC delivers on it five pillars plan and looks ahead to the modernisation of its legislative framework. The COO could represent the EC at IAMRA meetings. IAMRA operates a tiered fee structure. The maximum amount the EC would need to pay is $4,400 US dollars per annum but IAMRA have discretion to reduce that, and a lower fee could be negotiated. It would certainly deliver value for money, for example, in supporting policy development and change.

10.4 In the meantime, it would be helpful for the EC to gather information about its peers in the regulatory community in the Caribbean. For example, it would be hugely beneficial to know what the level of the ARF is charged by each regulator, and key data on registration and disciplinary volumes. This would enable benchmarking against other jurisdictions in the region. The Caribbean Association of Medical Councils (CAMC) of which the MBTT is a member, may be able to provide the necessary data for this work.

Recommendation 19: *The EC should apply to be members of IAMRA (D).*

11 Conclusions

11.1 Medical regulation has changed in a number of very significant ways in the past 25 years. A series of scandals across the world involving doctors dented confidence in traditional modes of 'self-regulation' and led many regulators to bring a broader group of stakeholders into their governance structures, alongside doctors. The 2007 changes to the Medical Act reflected this evolving view of regulation and the need for greater public involvement in regulatory governance. The review has found that, welcome as these changes have been, there is more still to do in this area, in particular by taking steps to bolster the independence and transparency of the EC and to remove any perception that the EC is formally accountable to medical doctors alone. This will require further changes to the 1960 Medical Act, which the EC recognises needs fundamental overhaul in a number of areas.

11.2 The review has also concluded that the structure of the EC needs to adapt in order to address challenges driven by the significant growth in the volume and complexity of the registration process and fitness to practise cases, together with the need to communicate more pro-actively with the medical community and other stakeholders. This requires strengthening of the current operating model, which is heavily dependent on the voluntary, part-time contributions of EC members, both medical and non-medical, who have busy professional lives outside of the MBTT.

11.3 In order for the EC to become the efficient and effective organisation it aspires to be, it will be necessary to bring in extra staff with additional capabilities, and to establish a new role of COO to provide leadership of the executive, help resolve the litigation and cost issues highlighted by interviewees, ensure the development of the organisation in accordance with the five pillars plan and provide continuity in the senior advice and support given to the EC.

11.4 The five pillars programme provides a sound basis for modernising and professionalising the EC. It will need to be turned into a detailed, costed and prioritised plan with agreed milestones and key performance indicators. This in itself is a very significant task, but one which an experienced and capable COO will be able to carry out. There is every reason to think that within the time period of the five pillars programme (2021-2026) it will be possible to achieve the step change in performance that the EC wishes to see.

11.5 Finally, prioritising the five pillars and implementing projects borne from it such as the online payment system, integration of this system into a new and engaging website, an online medical register, the standardization of disciplinary procedures, training for panelists and making the required changes to the Medical Act, are all areas where GMCSI can offer trusted business advice and work in partnership with the EC. We hope to continue our working relationship, offering our support as you progress through your journey in executing the five pillar model.

12 Annexes

Annex 1: Phase 2 Interviewees

Executive Council Officers

Dr Lesley-Ann Roberts – President (MOH appointee)

Professor Hariharan Seetharaman – Secretary (elected by MBTT)

Dr Stanley Giddings – Treasurer (UWI nominee)

Members elected by the MBTT

Dr Peter Baggan

Dr Kenneth Charles

Dr Krishan Ramsoobhag

Member nominated by the Law Association

Mrs Lynette Seebaran-Suite

Member nominated by the Inter Religious Organisation

Pundit Mukram Sirjoo

Medical Board staff

Carrie Olton – Executive Secretary

Kavita Parsan-Macoon – Secretary

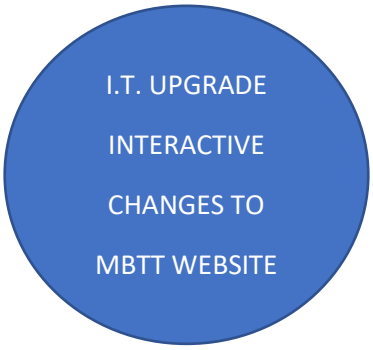
Other interviewees

The GMCSI also spoken to senior doctors with association to the MBTT to get their perspective on perceptions of the effectiveness of the EC.

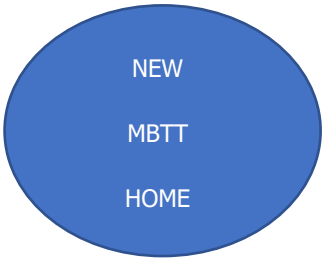
Annex 2: Abbreviations

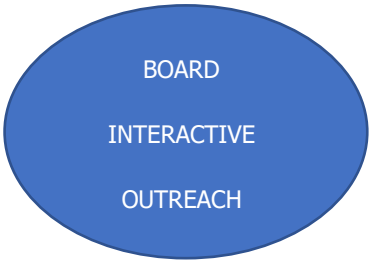
Acronym	Meaning
ARF	Annual Retention Fee
CEO	Chief Executive Officer
COO	Chief Operating Officer
CME	Continuing Medical Education (sometimes called Continuing Professional Development)
EC	Executive Council of the Medical Board
GMC	General Medical Council of the UK
GMCSI	GMC International Services Ltd
IAMRA	International Association of Medical Regulatory Authorities
MBTT	Medical Board of Trinidad and Tobago
MoH	Ministry of Health
PID	Project Initiation Document
S	Schedule
TTMA	Trinidad and Tobago Medical Association

Annex 3: "Five Pillars' Strategic Plan



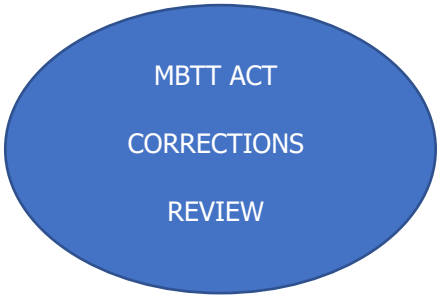
1. Change format.
2. More functions online.
3. Zoom friendly.
4. Public/Private platforms.





1. Land acquisition.
2. Building plans. (Integrated conference center).
3. Build.

1. Electronic newsletter. (public /private)
2. Sensitization on MBTT Act.
3. Guidance on CME's.
4. Decimination of policies.



1. Corrections of ambiguity in Act.
2. Change ARF to Annual license.
3. Conform to Joint Select. Committee report.
4. Legal Retreat.

1. Review Structure. (GMC/Barbados/Jamaica).
2. Consider in-house Junior Counsel.
3. Consider C.O.O.
4. Develop "Business Arm".

MOVING FORWARD.

1. Appoint Overall Coordinator for Change Management.

2. Appoint sub-committees for each area.
   (sub-committees can recruit members of the General Board.
   Communication with Council would be through reports).

3. Sub-committees to propose: Short – Medium-Long-term Goals.

4. Introduce the concept of change (page 1) at virtual AGM Dec 16th and invite comments/suggestions from the general membership.

Annex 4: IAMRA Principles in Medical Regulation

Medical regulatory authorities serve in the best interest of the public. Their mandate is to protect, promote and maintain the health and safety of the public by ensuring proper standards for the profession of medicine.

The International Association of Medical Regulatory Authorities (IAMRA) expects that medical regulatory authorities that are members of IAMRA will strive to apply the following five principles in the administration of their mandate:

1. Accountability / Acceptability

Medical regulatory authorities operate in such a manner as to be able at all times to explain, justify or render accounts about all their activities to the public, government or other stakeholders. They will do so in the appropriate social, cultural and economic contexts.

2. Fairness

Medical regulatory authorities operate within established standards, rules, regulations, guidelines, by-laws, policies or legislation that are free from favouritism, self-interest, bias or deception.

3. Feasibility/Affordability

Medical regulatory authorities operate within the social, political and fiscal realities of the times, without compromising the other principles laid out in this document.

4. Materiality

Medical regulatory authorities ensure that all their actions and activities are justifiable according to the mandate stated above. These actions and activities may include some or all of the following: registration, licensure, discipline, education, ongoing competence and rehabilitation / remediation of physicians.

5. Transparency / Openness

Medical regulatory authorities clearly define and readily communicate their mandate, their rules and regulations, their processes and procedures, and all other activities to their major stakeholders, ie, the public (including patients), physicians and government. Medical regulatory authorities consult their major stakeholders when and where appropriate before establishing rules and regulations, and processes and procedures.

Annex 5: Sample Job Descriptions

Example of a COO Job Description

Job brief

We are looking for an experienced **Chief Operating Officer or COO** to lead all aspects of the GMC operational management, ensuring the delivery of its strategic objectives and operational plans in line with its statutory responsibilities. You will oversee our organisation's ongoing operations and procedures. You will be responsible for the efficiency of the business. The COO role is the leader of the support team, reporting only to the President. You'll have to maintain control of diverse business operations, so we expect you to be an experienced and efficient leader. If you also have excellent people skills, business acumen and exemplary work ethics, we'd like to meet you.

Responsibilities

- Accountability for the effective management and strategic planning of resources in line with the relevant legal and regulatory requirements
- Set comprehensive goals for performance and growth
- Act as a key adviser to the Executive Council on all operational matters, ensuring the integration of operational plans and resources with agreed strategy and policy
- Establish policies that promote culture and vision
- Oversee daily operations of the organisation and the work of its staff
- Lead employees to encourage maximum performance and dedication
- Evaluate performance by analyzing and interpreting data and metrics
- Write and submit reports to the Council in all matters of importance
- Manage relationships with key national and international stakeholders
- Ensuring high levels of staff morale and a shared determination throughout the organisation to embrace the values and objectives of the organisation with an overriding commitment to protect patients.

Requirements

- Proven experience as Chief Operating Office or relevant role
- Understanding of business functions such as HR, Finance, marketing etc.
- Demonstrable competency in strategic planning and business development
- Working knowledge of data analysis and performance/operation metrics
- Working knowledge of IT/Business infrastructure and MS Office
- Understanding of medico/legal issues and of working in a regulatory environment
- Outstanding organisational and leadership abilities
- Excellent interpersonal and public speaking skills
- Aptitude in decision-making and problem-solving
- Relevant degree-level qualification(s)

Example of a Legal Officer Job Description

Job brief

We are looking for a self-motivated Legal Officer to ensure smooth running of the office and effective case management. You will provide a broad spectrum of legal services under the supervision of an attorney.

Responsibilities

- Provide administrative support to lawyer and enhance office effectiveness
- Handle communication with clients, witnesses etc.
- Administratively support and attend trials
- Prepare case briefs and summarize depositions, interrogatories and testimony
- Conduct investigations and statistical/documentary research
- Locate and develop case relevant information
- Type up and file basic legal documents and correspondence

Requirements

- Proven working experience as Legal Assistant or Legal Secretary
- Familiarity with law, legal procedures and protocols, and court system
- Satisfactory knowledge of day-to-day operations of a legal office
- Computer literacy
- Proficiency in English
- Working knowledge of case management software
- Excellent secretarial and organisational skills
- Ability to juggle multiple activities and work under pressure
- Legal Assistant certification or diploma

Source: Chief Operating Officer - COO job description template | Workable

Example of a Digital Communications Officer

Job brief

We are looking for an enthusiastic Communications Specialist to manage our external and internal communications. You will promote a positive public image and control the dissemination of information on our company's behalf.

Phenomenal communication and copywriting skills make a strong communications specialist. Experience in corporate communications and project management are important qualities too. Your enthusiasm and positive attitude will help you gain the trust of colleagues and external parties alike.

Responsibilities

- Develop effective corporate communication strategies
- Manage internal communications (memos, newsletters etc.)
- Draft content (eg press releases) for mass media or company website
- Organize initiatives and plan events or press conferences
- Liaise with media and handle requests for interviews, statements etc.
- Foster relationships with advocates and key persons
- Collaborate with marketing professionals to produce copy for advertisements or articles
- Perform "damage control" in cases of bad publicity
- Facilitate the resolution of disputes with the public or external vendors
- Assist in communication of strategies or messages from senior leadership

Requirements

- Proven experience as communications specialist
- Experience in web design and content production is a plus
- Experience in copywriting and editing
- Solid understanding of project management principles
- Working knowledge of MS Office; photo and video-editing software is an asset
- Excellent communication (oral and written) and presentation skills
- Outstanding organisational and planning abilities
- Proficient command of English
- BSc/BA in public relations, communications or relevant field

Source: Chief Operating Officer - COO job description template | Workable