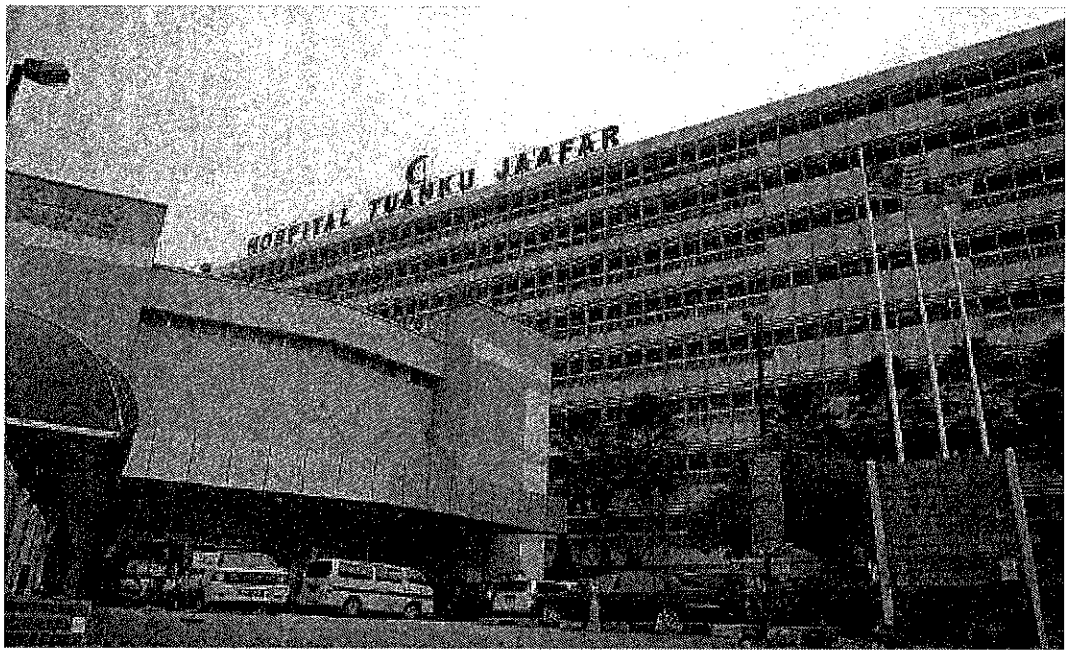
Kementerian Kesihatan Malaysia

Hospital Tuanku Ja'afar Seremban

POLISI MEDICAL STAFF BY LAWS
HOSPITAL TUANKU JA'AFAR SEREMBAN



Disediakan:	Disahkan:
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TARIKH KEMASKINI TERDAHULU:
TARIKH KEMASKINI TERKINI :

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Preamble

WHEREASE, This Hospital Provides the highest possible standard of medical education; and serve as referral centers and to provide academic training; and

WHEREASE, it is recognized that the Medical Staff has main responsibility for the quality of medical care provided to patients and must accept and discharge this responsibility subject to the ultimate authority of the Ministry Of Health (MOH), and that the cooperation of the Medical Staff, and the Director are necessary to fulfill the hospital's obligation to its patients; and **NOW THEREFORE**, the Physicians and Dentists Practicing in Hospital and related facilities hereby are established as a Medical Staff in conformity with these By-laws.

Introduction

1. **Hospital**: Hospital Tuanku Ja'afar Seremban.

2. **Hospital Policy**: A set of By-Laws governing total medical administration and operation of the program / Hospital.

3. **Medical Staff**: Includes all Medical, Dental and Allied Health Professionals appointments to the program / Hospital.

1. Objectives

The objectives of Hospital Tuanku Ja'afar Seremban Medical Staff By-Laws are:

1. To ensure that all patient admitted to or treated in any part of the Hospital shall at all times receive the best possible care and attention.

2. To ensure the maintenance of the highest level of professional performance and behaviour by all Medical Staff.

3. To provide an appropriate educational setting that will maintain high standards, and will advance professional experience and knowledge of Medical Staff of the Hospital.

4. To serve as a reference for the Hospital Director when required on matters concerning the discipline of medical staff, the appointment and re- appointment of medical staff, and the policies and procedure to be followed by Medical Staff in the performance of their duties.

5. To advance research on medical and scientific issues of relevance to patients and the Hospital Tuanku Ja'afar in accordance with ethical standards and with the MOH Guidelines for research.

6. To ensure compliance with the MOH Standards or Policies for Medical Staff.

7. To initiate and maintain medical staff policies and procedures, rules and regulations.

8. To assist in the preparation of emergency and major disaster plans which will ensure the maximum optimal response of the hospital, when required.

2. Definition of Terms

The meanings set out in the Definition of Terms are to be attributed to such terms as used in these By-laws when capitalized unless otherwise clearly required by the context in which such terms area used. In consulting these By-laws, the reader should first familiarize himself with the Definition of Terms.

When used in connection with the Medical Staff By-laws, the following terms shall have the meaning given below unless otherwise specified or unless otherwise clearly required by the context in which they are used:

Allied Health Professional – an individual, possessing qualifications in one of the categories of ancillary health care which may be determined from time to time by the Hospital Director, Hospital Committee or program Supervisor to be beneficial to and required for patient care within the Hospital.

Appeal – an application from a Medical practitioner, who is the subject of a warning or limitation of Clinical Privileges, requesting reconsideration of the decision to impose a Corrective Action as defined below.

Assigned Supervisor – a qualified Practitioner or Allied Health staff who was appointed by the Credentialing and Privileging (C&P) Committee to supervised a trainee or C&P applicant.

Attending Physician – the Qualified Medical Practitioner or Oral Surgeon possessing Inpatient Privileges, who is responsible for the overall care of the patient and for the maintenance of adequate documentation in the patient's medical record.

Categories – descriptions of the types of Medical Staff according to status ("Permanent"/ "Trainee"/ "Temporary").

Clinical Privileges – specific rights granted to individual Practitioners authorizing the admitting of patient and/or the carrying out of designated investigations and/or procedures.

Corrective Action – the process activated in the event of the finding of substandard professional practice.

Dentist – graduate from a recognized dental school.

Department – a principal organizational element of the Medical Administration, created either by the program/ hospital structure or by approval of the Hospital Management Team on the recommendation of the MOH.

Division – a semi-autonomous major administrative and organizational element within a Department created either by the program/ Hospital structure or by approval of the Hospital Management on the recommendation of the MOH.

Emergency – a situation in which there is an immediate danger of loss of life or serious disability and in which any delay in treatment might increase that danger.

Employee Specification & Job Description – the legal document which describes in detail each authorized employee's position in terms of organizational relationships, duties, responsibilities and qualifications.

Ethics – moral principles and values adopted by the particular profession of each Practitioner and Allied Health Professional which shall be consistent with the policies of the Hospital and Laws Governing the practice of medicine within Hospital Tuanku Jaafar

Head of Department – a functional title of the physician or Allied Health staff, appointed as professional administrator of a division.

Hospital Director – the person appointed by the Ministry of Health (MOH) as its representative at hospital to administer, monitor and supervise all the Hospital / program functions.

Human Resources Department – Previously Manpower Department.

Licensure – License to practice in the indicated field of medicine from the Malaysian Medical Council and Allied Health Council.

Notice – the oral or written transmission by posting within the Hospital, inclusion in publications distributed to the intended recipients, general announcements telephone, personal delivery, mail delivery or any other means reasonably calculated to inform.

Physician – refers to a graduate from recognized university and licensed to practice medicine.

Policies of the Hospital – includes Medical Staff Rules and Regulations, Hospital wide policy, Hospital Committee's policy and directives of MOH.

Practice Privileges – specific right granted to Practitioner and Allied Health Professional authorizing the carrying out of designated investigations and/or procedures.

Practitioner – any physician or dentist licensed by the Malaysia Council for Health Specialties (SCHS) to practice his profession within the Malaysia.

Prerequisite – a condition which must be demonstrated to exist with respect to a Practitioner or Allied Health Professional as a prior requirement for a status or position.

Prerogative – a participatory right granted to a practitioner or Allied Health Professional within the limitations provided by these By-Laws and other Policies of the Hospital.

Qualifications – all of the factors which are prerequisites to eligibility for or which are relevant to, the evaluation of an individual for a particular Appointment or undertaking.

Senior Specialist – Previously; Senior Registrar.

Specialist – Previously; Registrar.

Quality Management (QM) – the ongoing activities designed objectively and systematically to evaluate the quality of patient care and services, pursue opportunities to improve patient care and services and resolve identified problems.

Unit – any facility within the hospital, a division or sub-specialty, designated to fulfil a certain diagnostic, therapeutic or preventive functional.

Warning – a verbal or written communication issued by way of Corrective Action to a Practitioner or Allied Health Professional indicating that his or her performance has been found to be below acceptable standard and requiring improvement to be demonstrated.

3. Categories and Grades of the Medical Staff

3.1 Categories of the Medical Staff

There shall be four (4) categories of the Medical Staff:

Permanent, Visiting, Temporary (locum) and Trainee.

Permanent Medical Staff - are responsible on a regular basis for the care patients treated within the Hospital including emergency care and consultation. Members of the Permanent Medical Staff shall be employees of the Programme / Hospital of MOH, shall have defined clinical privileges, shall serve on the Medical Staff Committees as appointed and shall be required to attend the medical staff meeting.

Visiting Medical Staff - are those members of the medical professions who are invited by the Programme/Hospital to undertake the care of patients, teaching or research within the hospital. Visiting medical staff shall be granted the same privileges accorded to Permanent Medical Staff (with the exception of admission privileges), based on recommendation of the Credentials and Privileging Committee to the Hospital Management Committee.

Temporary (Locum) Medical Staff - status applies to Medical Practitioner appointed to the Medical Staff on a locum basis. The Programme/Hospital Director, based on the recommendations of the Credentials and Privileging Committee, shall grant all the clinical privileges accorded to them.

Trainee Staff - shall consist of Houseman fellows or any other individuals who are trainees. Except in the case of rotating interns, trainee staff shall be assigned to a specific clinical department. Interns shall be required to meet the educational and training standards of the medical school; from which they graduated.

3.2 Grades of the Medical Staff

Service Title: The job titles of Services Medical Staff shall be as follows:

i. **Head** —Shall be a consultant who wills carrying out the duties as defined in his/her job description.

ii. **Consultant-in-Charge** — Shall be a consultant who, in addition, be responsible for the running/operation of a diagnostic, preventive or therapeutic Medical Unit or a Medical Subspecialty within Hospital.

iii. **Consultant** — Shall be responsible for advising, supervising and teaching the Senior Registrars and junior Medical Staff attached to their Department, in addition to his/her clinical responsibilities.

iv. **Senior Specialist** — Shall be accountable to a named member of the Consultant Staff for the care of both in-patients and out-patients and shall be responsible for advising, supervising and teaching the Junior Medical Staff in the Department, in addition to his/her clinical responsibilities.

v. **Clinical Specialist** — Shall be accountable to a named member of the Consultant staff for the care of both in-patients and out-patients and shall be directed by the Consultant and/or Senior Specialist in the fulfilment of his/her duties. He/she shall be responsible for advising, supervising and participating in the teaching of the Junior Medical Staff in the Department, in addition to his/her clinical responsibilities.

vi. **Trainee Titles:**

The job titles of Medical staff in training shall be follows:

Houseman — To be entered by those doctors upon graduation. The post is to be held for two years and is to be on a rotational basis through various Departments as laid down by the Regulations of the particular Medical School from which

he/she graduated. He/she shall be accountable to a named member of the Consultant, Specialist, Medical Officer of the Department in which he/she is rotating in at the time. Administrative responsibility for the Houseman shall be held by the Deputy Director of Hospital (Medical).

The job titles of Allied Heath staff in training shall be follows:

Trainee Allied staff — This includes nurses, Medical Laboratory Technician and other allied health who were sent to hospital for attachment. A directive letter of approval shall accompany each staff upon report duty. It is the responsible of the head of unit to monitor those staff and to follow the directive letter from Jabatan Kesihatan Negeri.

4. Appointment, Re-Appointment Assignment and Clinical Privileges

4.1 Application for Appointment

4.1.1 Application for membership of the medical Staff shall be submitted on the prescribed forms and signed by the applicant to the JPA / SPA /MOH (Appointment of Government Central Agency).

4.1.2 The applicant for Credentialing and Privileging
Be responsible for producing adequate information for proper evaluation.

4.1.3 The completed applications shall be processed in the manner indicated in Hospital Tuanku Ja'afar policies governing Credentialing and Privileging Process. All applications will be reviewed by the Head of Department (HOD) who will compile for submission to the Credentials and Privileging Committee. The Credentials and Privileging Committee shall then examine the evidence of the character, professional competence, qualifications and ethical standing of the practitioner and shall determine with the relevant clinical department through information contained in the reference given by the applicant, and form all other sources available to the Committee, whether the applicant meets all the necessary prerequisites for the category, grade of staff, and the clinical privileges relevant to the post.

4.1.4 The Credentials and Privileging Committee shall transmit a written report of its findings with recommendations included in the presentation form to the Hospital Director.

4.2 Assignment

4.2.1 Assignment to the Hospital Tuanku Ja'afar Staff may be granted to professionally competent Medical Practitioners who continuously meet the qualifications, standards and requirements set forth below:

i. The specific qualifications and experience requirements for categories and titles of Medical Staff as set forth in the Standardized Employee Specification and Job Description of MOH Hospitals.

ii. Documentation of the experience, training, demonstrated competence, adherence to the ethics of the profession, good reputation, ability to work with others, and physical and mental health, with sufficient adequacy to assure the Medical Staff and the Programmed/hospital Director that any patient treated within the Programmed/Hospital by the applicant medical practitioner would be given a high quality of medical care.

4.2.2 The initial assignment of every member of the Medical Staff shall be provisional for three months as a probationary period.

Before the end of this period, the Head of Department (HOD) shall recommend via the Credentials & Privileging Committee to Hospital Director whether or not the assignment of the Medical Staff member shall be continued, and whether or not the clinical privileges granted on assignment shall be continued. Such recommendation shall be based on direct observation by the Head of Department or his designee of a suitable number of cases managed, review of medical records of patients treated and reviews of results of departmental QM activities.

The Staff member has no right to appeal against termination or modification of clinical privileges resulting from assessment of his/her performance during the probationary period.

4.2.3 Assignment to the Medical Staff implies that he/she will strictly abide by the Hospital Tuanku Ja'afar Medical Staff By-Laws, Rules and Regulations, Code of Medical Ethics and By-Laws governing the practice of Medicine in Malaysia.

Furthermore, it is implied that the Practitioner shall provide continuous medical care and supervision of his/her patients, accept committee assignments, accept consultation requests where appropriate and participate in emergency care on request.

4.3 Re-Assignment

4.3.1 Re-assignment shall be on the recommendation of the Practitioner's Head of Department (HOD) of division and approval of the Credentials & Privileging Committee. This will be based on periodic appraisal of the Medical Staff member, which shall take place annually, not less than six months, before the end of the current contract.

4.3.2 The Credentials & Privileging Committee shall review all pertinent information available on each Medical Staff member scheduled for periodic appraisal, for the purpose of determining their recommendations for re-appointment or non-reappointment to the Medical Staff and for the granting of clinical privileges for the ensuing period and shall transmit their recommendations in writing to the Department of Human Resources.

4.3.3 Each recommendation for re-assignment of a Medical Staff member and the clinical privileges to be granted on re- assignment shall be based upon the Medical Staff member's record of professional competence and clinical judgment in the treatment of patients, including:

i. An examination of the individual's pattern of care as demonstrated by reviews conducted by committees involved;

ii. The individual's maintenance of timely, accurate and complete medical records;
iii. The individual's attendance at required staff departmental meetings;
iv. The individual's ethical conduct and general behaviour;
v. The individual's general application to his/her work;
vi. The individual's compliance with the Hospital Policies, Medical Staff By-Laws and Rules and Regulations; and
vii. The individual's physical and mental health
viii. The individual's administrative and academic activities in his/her department/division, including participation in the QM programme.

4.4 Clinical Privileges

4.4.1 The Head of Department / Unit shall recommend to the Credentials and Privileging Committee the clinical privileges to be granted to each member of the medical staff and act on requests for additional privileges. The recommendations shall be based upon the Practitioner's education and training, qualifications, professional experience, current licensure to practice in the country from which the person was recruited, health status (physical and mental) and other relevant information, including an appraisal by the departmental divisional head of the member of Medical Staff or by the Director of a Hospital if a head of department being considered. Every member of the medical staff shall be entitled to exercise only those clinical privileges approved by the Hospital Director.

4.4.2 Granting of clinical privileges shall be provisional, initially by the head the department in which the Practitioner will be employed. Periodic re-determination of clinical privileges shall be based on the direct observation of the care provided, review of the reports of the Head of Departmental.

4.4.3 Temporary clinical privileges of visiting Medical Staff may be granted by the Hospital Director to a Medical Practitioner upon the basis of information made available to him which may reasonably be relied upon as to the competence and

ethical standing of the Practitioner and with the written concurrence of the Head of Department concerned.

In all such cases, visiting Medical Staff members shall act under the supervision of the Head of Department (HOD) to which he has been assigned and shall abide by the Medical Staff By-Laws, Rules and Regulations of Medical Staff.

Medical staff serving on locum basis may be granted such temporary privileges.

4.4.4 In cases of emergency, any member of the Medical Staff, even junior doctors not ordinarily accorded such privileges, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility at the hospital necessary, including the calling of any consultation necessary or desirable.

When an emergency situation no longer exists, the appropriate member of the Medical Staff shall continue the treatment of the patient. An emergency is defined as a condition in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

5. Executive Members of The Medical Staff

5.1 The Executive Members

Members of the Medical Staff shall be

i. Hospital Director
ii. Deputy Director (Administration)
iii. Deputy Director (Medical)
iv. Head of Department / Head of Units

5.2 Qualifications of Executive Members of the Medical Staff

The Executive Members of the Medical Staff must be members of the active Consultant Medical Staff at the time of selection and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the offices involved.

5.3 Selection of Executive Members

The Executive Members of the Medical Staff shall be selected by the Hospital Director.

5.4 Terms of Office

Executive Members shall serve until a successor is selected by the Hospital Director.

5.5 Duties and Definition of Responsibilities of Executive Members

5.5.1 Medical Administration Office Composition

i. Director of Hospital
ii. Deputy Director (Medical)
iii. Deputy Director (Management)
iv. Assistant Director (Management)

5.5.2 Responsibilities

i. Ensures the effective management of the Clinical Departments of the Hospital/Programme by assuming overall administrative responsibility including Policies, Budgets and Establishments and to co-ordinate their activities with each other and with non-clinical departments within the Programme.

ii. Ensures medical staff's adherence to hospital policies, Medical Staff By-Laws, rules and regulations of the medical staff and codes of medical ethics.

iii. As the area administrator and budget holder of the medical sector of the hospital, he is responsible to the Hospital Director for the efficient utilization of manpower and financial resources of the medical and paramedical departments.

iv. Facilitates the provision of the highest possible standard of medical care to patients according to MOH standard and within available resources.

v. Reports to the Hospital Director (Chairman of the Hospital Steering Team) any deviation from the MOH standard in performance and quality of patient care together with appropriate proposals for improvement.

vi. Acts as the representative of medical staff to the State Director and in all higher committees.

vii. Ensures the development and regular update of departmental operational policies and procedures by the directors/heads of medical and paramedical departments/divisions, for the purpose of regulating clinical work and enhancing the co-operative relationship between the various departments in the patient's best interest.

viii. Ensures that on-call duty rotes of all medical and paramedical departments are finalized and submitted in a timely manner to the Department of Medical Administration.

ix. Monitors Specialist Clinic utilization and inpatients activities of the hospital, including the length of stay, the occupation rate, permanent bed allocation in all specialties/departments and recommends any corrective action,

regarding redistribution of beds, as seemed necessary, to the Hospital Director.

x. Performs annual appraisals of all Head of Department (HOD) and heads of paramedical departments and raises his recommendations to the State Director.

xi. Reviews, evaluates and recommends staffing establishment changes of medical and paramedical departments to the hospital director or Hospital Steering Team, with the objective of economically and effectively meeting the service demand.

xii. Is Responsible for processing government and other official clinical communications.

xiii. Is Responsible for assignment of medical teams/escorts and other medical services offered to VIPs in and outside the hospital and for the coverage of official missions.

xiv. Receives, evaluates, prioritizes and presents as Chairman of the Equipment Evaluation Group (EEG) all capital equipment requests from Head of Department.

xv. Monitors in conjunction with Department of Human Resources the recruitment process of medical and paramedical staff, including pharmacists and medical physicists, identifies potential severe shortages in the service provision and proposes solutions to the Hospital Director or Hospital Steering Team.

xvi. As Chairman of the Credentialing and Privileging Committee, he is to organize, supervise and control medical staff promotion, new appointments and extension of contract and to recommend clinical privileges of individual medical staff to the Hospital Director.

xvii. In conjunction with Education, Training and Research Units to promote symposia, conferences, workshops, other continuous medical education activities and research activities hospital wide.

xviii. Serves as Chairman of the Medical Records Committee and to monitor the number of incomplete medical records and undertake any corrective measures.

xix. Serves as Chairman of the of Medical Staff Meeting and the Credentialing & Privileging Committee and in other hospital committees, as indicated.

xx. Responsible for the implementation of sanctions where these are needed, and for the medical staff's compliance with procedural safeguards in all instances where corrective actions have been requested against a member of medical staff.

xxi. As Area Administrator he/she is the authorized signatory for the time sheets of all medical and paramedical departments/divisions, for the advanced payment forms of all missions/business travel claims and for the compensation of excess hour claims submitted by medical and paramedical staff.

xxii. Ensures the regularity of the meetings of Medical Dental Advisory Committee (MDAC), Departmental Meetings and the meetings of the Departmental QM Teams in all medical departments, as per MOH Guidelines and Medical Staff By-laws.

xxiii. He is responsible for the development and update of the Hospital Major Disaster Plan and to ensure that all medical, nursing and paramedical staff are aware of their responsibilities and roles in the hospital response to major disaster.

xxiv. Serves as the Principal Hospital controller of the Major Disaster Plan.

REPORTS TO: Hospital Director.

6. Clinical Departments, Divisions and Units

6.1 Medical Staff

Medical Staff is organized as clinical management groups, as follows:

6.1.1 Department

The Department shall be defined as a principal independent group of Medical Staff, usually specialized and shall be managed by a HOD. The Department may be further comprised of Units.

6.1.2 Unit

The Unit shall be defined as a semi-autonomous organizational group of Medical Staff and shall be managed by a Head, who shall report to the Head of the mother Department.

6.2 Organization of Clinical Departments

6.2.1 Medical Staff shall be organized into departments, e.g.

i. General Medicine
ii. Nephrology
iii. Dermatology
iv. Psychiatry and Mental Health
v. General Surgery
vi. Neurosurgical
vii. Orthopedics
viii. Otorhinolaryngology (ORL)
ix. Ophthalmology
x. Anesthesiology
xi. Rehabilitation Medicine
xii. Emergency and Trauma

xiii. Oral and Maxillofacial Surgery (OMFS)
xiv. Pediatric Dental
xv. Obstetrics and Gynecology (O&G)
xvi. Pediatric
xvii. Pathology
xviii. Forensic
xix. Radiology Diagnostic and Imaging
xx. Pharmacy
xxi. Transfusion Medicine

6.2.2 The Unit may become established as separate Departments in their own right, as deemed advisable and requested by the mother Departments, recommended by the MDAC and approved by the Hospital Director State Director.

6.2.3 Units may establish policies and procedures consistent with overall departmental and hospital-wide medical policies, but shall be directly accountable to the mother department within which they function.

6.2.4 Medical training and education programmes shall be coordinated through the Training Unit and Quality Unit who shall report to the Director of Medical Administration.

6.3 Functions of Department

6.3.1 Each Department shall participate in the evaluation of medical care by members of the Department through the mechanism of a distinct Total Quality Management meeting, which shall be held on a scheduled basis. Such meetings shall review mortality, morbidity, incidents and untoward occurrences, which relate to patient care and utilization of hospital resources.

6.3.2 A report shall be submitted monthly to the MDAC Team detailing such departmental analysis of patient care.

6.3.3 Develop and make recommendations for the establishment of operational policy & procedures in line with MOH standards.

6.3.4 Develop and make recommendations for the establishment of standards of clinical practice, which are expected to be met by Practitioners, awarded Privileges in the Department in accordance with MOH Standards.

6.3.5 Develop and conduct programmes of monitoring and evaluation of clinical services performed by the Department in terms of conformity with such established MOH standards.

6.3.6 Develop and conduct programmes of continuing education for Practitioners awarded Privileges in the Department.

6.4 Privileges in the Department

6.4.1 Meet monthly for the purpose of discharging the foregoing functions and of promoting the quality of care rendered by the Department including, but not limited to:

i. The review of appropriate Performance Improvement reports studies.
ii. The formulation of recommendations to the MDAC Team.
iii. Develop and conduct clinical studies and research programs.
iv. Submit to the MDAC Team minutes of its meetings and other reports concerning its activities and recommendations

6.5 Meeting of Departments

6.5.1 Meetings shall be conducted in accordance with the provisions of the Rules and Regulations

6.5.2 Each Department of the Medical Staff shall conduct the following meetings:

i. Departmental Management Meeting including QM (Monthly at least 6 per year)

ii. Departmental Educational Meetings (CME)

6.6 Establishment or Consolidation of Departments

6.6.1 At such times as it may deem appropriate, the MDAC Team with the approval of Hospital Director may establish, consolidate or dissolve Departments.

7. Clinical Meeting

Clinical Specialist meeting shall be a standing committee and shall comprise of Medical Committees.

7.1 Medical Dental Advisory Committee (MDAC)

7.1.1 Composition

The Medical Dental Advisory Committee shall be a standing Committee and shall comprise:

i. Deputy Medical Director (Secretary)
ii. Chairman of the Medical and Psychiatry Directorate
iii. Chairman of the Surgical and Emergency, Women and Children Directorate
iv. Chairman of the Clinical Diagnostic and Forensic Directorate
v. Chairman of Diagnostic and Clinical Support Services Directorate
vi. Chairman of Operation Theatre Committee
vii. Chairman of Infection Control and Antibiotic Committee
viii. Others as and when required

7.1.2 Term of Reference:

i. Represent the views of the professional staff of the hospital on all aspects of patient care and matters related to professional staff.

ii. Advise the management on patient care policies.

iii. Advise the management on medical staffing including recruitment, credentialing and privileging, review of performance and continuous professional development.

iv. Advise on medical ethics and medico-legal issues

v. Recommend remedial actions related to consultant, specialist and Medical Officers.

vi. Review of performance of clinical disciplines through audit and QA activities.

vii. Any other matters which may be addressed to the MDAC by the hospital

7.1.3 Duties of MDAC

i. To represent and act on behalf of the Medical Staff, taking into consideration the need to abide by the Hospital By-laws and Rules and Regulations of Medical Staff.

ii. To develop the patients' care rules and be responsible to the Head of Department (HOD) for the application of the rules once approved by the Programme /Hospital Director.

iii. To receive, discuss the reports and recommendations made by the Departmental Management Teams and submit its recommendations to the Hospital Steering Team.

iv. To monitor QM activities, including morbidity and mortality review reports.

v. To priorities quality issues, e.g. proposals for improvement of patient care.

vi. To co-ordinate the activities and general policies of the various Departments.

vii. To review and decide on the Hospital Wide Policies & Procedures involving patient care and on medical intradepartmental operational policies.

viii. To ensure implementation of the approved policies of the Medical Staff in accordance with the Regulations and By-laws of the Hospital.

ix. To make recommendations and suggestions on the medical care and administrative affairs connected with the medical field to the Hospital Director and/or Hospital Steering Team.

x. To review the disputable issues raised by the Credentials and Appointments Committee on the professional standing of any member of Medical Staff and make the final decision.

xi. To take all necessary measures to ensure professional ethical conduct and competent medical performance on the part of all members of the Medical Staff and make recommendations for corrective action when necessary.

xii. To review and approve in principle all academic activities, including yearly conferences, workshops and symposia programmes, subject to final ratification by the Hospital Steering Team.

7.1.4 Attendance

Any member of the MDAC who fails to attend three consecutive meetings without good reasons will be referred to Hospital Steering Team for corrective action.

7.2 Head of Department/Unit Clinical Specialist Meeting

The Head of Department/Unit Clinical Specialist Meeting is a non-subcommittee meeting.

7.2.1 Composition:

i. Hospital Director
ii. Deputy Director (Clinical)
iii. Deputy Director (Management).
iv. Medical and Dental Advisory Committee
v. Department of General Medical
vi. Department of Psychiatry
vii. Department of Obstetrics& Gynecology
viii. Department of Pediatric
ix. Department of Pediatric Dental
x. Department of Ophthalmology
xi. Department of Anesthesiology
xii. Department of Emergency and Trauma
xiii. Department of General Surgery
xiv. Department of Orthopedic
xv. Department of Otorhinolaryngology
xvi. Department of Radiology
xvii. Department of Pathology
xviii. Department of Forensics
xix. Department of Oral Maxillofacial Surgery
xx. Department of Transfusion Medicine
xxi. Department of Pharmacy
xxii. Quality and Cluster Hospital Unit

xxiii. Occupational, Safety and Health Unit

xxiv. Infection Control Unit

xxv. The Chairman may ask for the presence of an "expert to a specific discussion point or research if necessary.

7.2.2 Purpose - To discuss on clinical related matters

7.2.3 Duties

7.2.3.1 Presentation by Department / Unit representatives on clinical related matters (if any).

7.2.3.2 Proposals / Applications of assets/ consumables/ Medical Equipment Non-Medical Equipment and to be submitted for Program / Hospital support.

7.2.3.3 Presentation on human resources for each Department / Unit

7.2.3.4 Arising issues and other matters

7.2.4 Meetings

The meeting will be conducted four times a year and shall maintain pertinent records of its proceedings and activities

7.3 Credentials and Privileging Committee

Each committee member must be appointed by the State Health Director based on the recommendations of the Hospital Director. If a committee member resigns or is transferred, a new appointment may be made as appropriate. The committee members appointed by the State Director shall serve for a term of three (3) years.

7.3.1 Composition

The Credentials and Appointments Committee shall comprise as follows:

7.3.1.1 A Chairman: Hospital Director

7.3.1.2 Minimum of 8 senior Specialist

7.3.1.3 Representatives from Nursing / Hospital Supervisor/AHPs according to needs.

7.3.2 Functions

To establish the authority and procedures for granting, monitoring, and revoking clinical privileges for medical officers and specialists to ensure the highest standards of patient safety and clinical competency.

7.3.3 Committee Meetings

All involved members will deliberate within the Hospital Privileging Committee meeting to grant privileging approvals to hospital staff. The Committee meeting conducted must consist of:

7.3.3.1 A minimum attendance of six (6) committee members is required for a meeting.
7.3.3.2 At least two (2) attending members must be specialists from core disciplines.
7.3.3.3 Committee members cannot appoint proxies (representatives) to attend or approve privileging on their behalf.
7.3.3.4 Representatives from other departments (non-members) may be invited to attend if necessary, depending on the specific cases being discussed.

7.3.4 Duties of the Credentials and Privileging Committee

7.3.4.1 Identify suitable candidates to be part of the Hospital Privileging Committee.
7.3.4.2 Lead and implement privileging activities at the hospital level.
7.3.4.3 Plan strategies to strengthen and empower privileging activities at the hospital level.
7.3.4.4 Monitor and evaluate the implementation and effectiveness of the hospital's privileging process.
7.3.4.5 Conduct meetings at least twice (2) a year, or as required based on the number of privileging applications received from staff.
7.3.4.6 Provide feedback to the State Health Department (JKN) regarding issues and challenges faced in executing privileging activities.

7.4 Drug and Therapeutics Committee

The Drug & Therapeutics Committee shall be a sub-committee of the Medical Dental Advisory Committees

7.4.1 Composition

7.4.1.1 A Chairman: Hospital Director
7.4.1.2 Medical Deputy Director
7.4.1.3 Representatives from various Departments
7.4.1.4 Head of Department (HOD) of Pharmaceutical Services
7.4.1.5 Other officers appointed by the Chairperson

7.4.2 Purpose

7.4.2.1 To develop, implement, and monitor policies and guidelines established at the hospital level, ensuring alignment with those set at the state and Ministry of Health (MOH) levels.
7.4.2.2 To ensure the rational and quality use of medications, as well as the implementation of safe medication practices.
7.4.2.3 To discuss and make decisions on issues related to medication management at the hospital level.

7.4.3 Duties of the Drugs and Therapeutics Committee

7.4.3.1 Updating the MOH Facility Drug Formulary – To evaluate and decide on drug inclusion, removal, prescriber category amendments, and patient use criteria at the hospital/institution/primary healthcare facility level in alignment with MOH requirements.

7.4.3.2 Inventory Management and Control – To monitor drug budget allocation, expenditure performance, and stock movement, including managing slow-moving and special-approval drugs to minimize wastage.

7.4.3.3 Monitoring of Drug Utilization – To assess drug utilization patterns and implement appropriate measures to ensure rational and appropriate use of medications.

7.4.3.4 Monitoring of Special Approval Drugs – To review, regulate, and establish criteria for the use of drugs requiring special approval, including for non-formulary emergency indications.

7.4.3.5 Monitoring of Medication Safety Activities – To oversee and ensure the implementation of medication safety practices through monitoring adverse drug reactions and medication errors with appropriate interventions.

7.4.3.6 Other Matters (if required) – To review drug utilization data (e.g., MASc) and make decisions on additional drug-related issues at the hospital level.

7.4.4 Membership

7.4.4.1 The representatives shall be nominated by the Hospital Director.

7.4.4.2 Membership in the committee shall be automatically terminated if specialists or officers leave the public service or are transferred out of the hospital.

7.4.5 Meetings

7.4.5.1 Meetings of the Drug and Therapeutics Committee (JKUT) are coordinated by the Pharmaceutical Department.

7.4.5.2 The committee shall meet at least twice a year; however, meetings may be convened at any time, either physically or virtually, subject to suitability or upon the Chairperson's directive in the interest of service delivery.

7.4.5.3 The Chairperson may delegate one of the senior committee members to chair a meeting on the scheduled date.

7.4.5.4 The quorum for meetings shall be two-thirds (2/3) of the total membership; representatives or alternate members shall not be counted towards the quorum and are not permitted to make decisions or vote on drug listings.

7.5 Hospital Infection and Antibiotic Control Committee (HIACC)

The HIACC shall be a sub-committee of the MDAC Team.

7.5.1 Composition

7.5.1.1 Hospital Director (Chairman)
7.5.1.2 Head of Infection Control Unit
7.5.1.3 Infection Control Unit – Secretariat
7.5.1.4 Infectious Diseases Specialist (Adult or paediatrics) as HIACC coordinator
7.5.1.5 Clinical Microbiologist
7.5.1.6 Head of Departments/ Units from all major disciplines
7.5.1.7 Pharmacist
7.5.1.8 Hospital Engineer
7.5.1.9 Head of Occupational Safety and Health Department
7.5.1.10 Head of Public Health Unit
7.5.1.11 Head of Hospital Nursing Matron

7.5.1.12 Chief of Assistant Medical Officer
7.5.1.13 Hospital Support Services Concessionaire Manager
7.5.1.14 Nursing Matrons of specific critical areas:
- Central Sterile Supplies Unit (CSSU) Manager
- Operation Theatre Nursing Matron/ Sister

7.5.2 Invited Attendance

7.5.2.1 The Chairman may invite any other party to attend the meeting for discussion of specific issues as indicated by the agenda. In addition, postgraduate trainees in Infectious Disease, Clinical Microbiology, or allied health professionals undergoing an Advanced Diploma in Infection Prevention and Control (IPC) may be invited to attend as observers as part of their in-service training.

7.5.3 Purpose

7.5.3.1 HIACC functions as a governance body to coordinate hospital activities in prevention and control of healthcare associated infection (HCAI), promote judicious use of antimicrobials and control the emergence of antimicrobial resistance organism (AMR).

7.5.4 Duties

7.5.4.1 The HIACC is responsible for developing policies and procedures related to infection prevention and control (IPC), AMR and antibiotics usage in the hospital.
7.5.4.2 HIACC will provide expertise on matters related to IPC and antibiotics usage.
7.5.4.3 Establish and monitor national performance indicators (e.g. KPIs) related to IPC and the appropriate use of antibiotics in the hospital.
7.5.4.4 Preparation and submission of report to State Infection and Antibiotic Control Committee (SIACC).
7.5.4.5 The committee reviews issue related to IPC and antibiotic use and advises the healthcare workers through the head of Department/ Unit.
7.5.4.6 Identified issues from this meeting will be raised at the SIACC meeting.

7.5.5 Meetings

7.5.5.1 Meetings shall be held at least twice a year.
7.5.5.2 Members of the committee shall be notified of the date and agenda of meeting at least two weeks prior to the meeting.

7.5.6 Attendance

7.5.6.1 The quorum of the meeting shall consist of at least 2/3 of the committee members.

7.5.6.2 If a member is unable to attend, he/ she should send senior representative from the department/ unit.

7.5.7 Emergency meetings and outbreak control

7.5.7.1 The chairman may convene an emergency meeting at any time and all members or theirs representatives will be notified accordingly.

7.5.7.2 Emergency meetings are arranged for the control outbreaks of infection and when the Infection Control Unit requires additional support and notification of the problem in accordance with the major outbreak policy.

7.5.7.3 The chairman will chair all emergency meetings and be in-charge of the technical aspect of the outbreak control measures.

7.6 Radiation Protection Committee

The Radiation Protection Committee shall be a sub-committee of the MDAC.

7.6.1 Composition

The Radiation Protection Committee shall be comprised of:

i. Hospital Director (Chairman)
ii. Deputy Director (Clinical)
iii. Department of Radiology
iv. Physicist
v. Department of General Medical
vi. Department of Pediatric Dental
vii. Department of Anesthesiology
viii. Department of Emergency and Trauma
ix. Department of General Surgery
x. Department of Orthopedic
xi. Department of Oral Maxillofacial Surgery
xii. Occupational, Safety and Health Unit
xiii. Nursing Unit
xiv. Assistant Medical Officer Unit

7.6.2 Purpose

7.6.2.1 The Program/ Hospital Radiation Protection Committee (RPC) is responsible for assessing the clinical impact of the application of hazardous radiations (ionizing and non-ionizing) in medical practice throughout the Program/Hospital.

7.6.3 Duties

7.6.3.1 Generation of local rules for the safe application of hazardous radiation in medicine in conformance with Atomic Energy Licensing Act 1948 (Act 304), Law of Malaysia Regulatory requirements, for the protection of the patient, the hospital staff and the general public.

7.6.3.2 Investigations of any incident/accident involving hazardous radiation and the taking of any necessary action.

7.6.3.3 Review of the following:

i. Accidents and incidents involving radiation.
ii. Personal Radiation Dose Monitoring reports.
iii. Contamination Survey reports.
iv. Laser Survey reports.
v. QC reports for radiology equipment.
vi. Quality Assurance Program in Radiology Service

7.6.4 Meetings

7.6.4.1 The Committee shall meet at least every 6 month and shall maintain pertinent records of its proceedings and activities which should be submitted to the Medical Dental Advisory Committees at regular intervals.

7.6.4.2 The Chairman has the authority to call ad hoc meetings as required.

7.6.5 Attendance

7.6.5.1 If a member is unable to attend, he/she should send a representative; this should occur no more than three times per-calendar year.

7.6.5.2 Failure to attend the meeting more than two times per calendar shall result in the nomination of a replacement.

7.7 Theatre Users Committee

Theatre Users Committee shall be a sub-committee of the Medical Dental Advisory Committees.

7.7.1 Composition

i. Head of Department (HOD) of Anaesthesia (Chairman)
ii. Head of Department (HOD) of Surgery
iii. Head of Department (HOD) of all Surgical Specialties
iv. Head of Department (HOD) of Transfusion Medicine
v. CSSU Sister/ Matron
vi. Chief Anaesthesia Technician or Medical Assistant
vii. Representative from the Quality Management Department

7.7.2 Purpose

7.7.2.1 To supervise the utilization of all Operating Theatres in order to ensure the smooth running and efficient management of the theatre and its facilities.

7.7.3 Duties

7.7.3.1 To supervise and manage all aspects of the following: Operation of Operating Theatres
7.7.3.2 Scheduling of Operating Theatres to ensure efficiency and effectiveness
7.7.3.3 Surgical and anesthetic supplies
7.7.3.4 Other business brought by individual Committee members.

7.7.4 Meetings

7.7.4.1 The Committee shall meet every three months or when urgent or special business requires the convening of a special meeting and will record minutes, which should be submitted to the MAC at regular intervals.

7.8 Blood Transfusion Committee

The Blood Transfusion Committee shall be a sub-committee of the MDAC

7.8.1 Composition

i. Hospital Director (Chairman)
ii. HOD of Transfusion Medicine
iii. All Consultant Hematologist and Senior Specialists
iv. Chief and Senior Technicians from the Blood Bank
v. Quality and Cluster Hospital Unit
vi. Representative from:
- Department of General Medical
- Department of Psychiatry
- Department of Obstetrics& Gynecology
- Department of Pediatric
- Department of Pediatric Dental
- Department of Ophthalmology
- Department of Anesthesiology
- Department of Emergency and Trauma
- Department of General Surgery
- Department of Orthopedic
- Department of Otorhinolaryngology
- Department of Oral Maxillofacial Surgery
- Department of Radiology
- Quality Unit

7.8.2 Purpose

To monitor all aspects of the Blood Transfusion Service in the Hospital.

7.8.3 Duties

To review and discuss the following:

7.8.3.1 Donor recruitment and safety
7.8.3.2 Safety of blood transfusion
7.8.3.3 Appropriate requesting of blood
7.8.3.4 Bloods stock for normal practice and major disaster
7.8.3.5 Relations between blood bank and Clinical Departments and problems arising

7.8.4 Meetings

7.8.4.1 The Blood Transfusion Committee shall meet at least every 3 months, or as deemed necessary by the Chairman and shall maintain pertinent records of its proceedings and activities, which it should submit to the MDAC at regular intervals

7.9 Medical Records Committee

The Medical Records Committee shall be a sub-committee of the Medical Dental Advisory Committees.

7.9.1 Composition

i. Hospital Director
ii. Head of Departments of General Medical, General Surgery, Orthopaedic, Otorhinolaryngology, Anaesthesiology, Emergency and Trauma, Radiology, Psychiatry, Ophthalmology, Forensic, Pathology, Transfusion Medicine, Oral Surgery, Paediatric Dental and others.
iii. Head of Quality Unit
iv. Head of Occupational Health Unit
v. Head of Medicolegal & Complaint Unit
vi. Head Of Casemix Clinical Coordinator
vii. Nursing Director
viii. Director of Assistant Medical Officer
ix. Medical Record Officer
x. Assistant Medical Record Officer
xi. Representative from Administration of any Satellite Hospital
xii. Medical Forms Officers

7.9.2 Purpose

7.9.2.1 To ensure all medical records meet the highest standard of patient care usefulness, of historical validity reflecting realistic documentation of medical events) and or completeness and that they are maintained in accordance with the MOH guidelines.

7.9.3 Duties

7.9.3.1 The Medical Records Committee shall direct the Medical Records Officer in ensuring that the Hospital's medical record are maintained in accordance with the MOH Guidelines and they shall make a

recommendation to the Medical Dental Advisory Committees in matters relating to the Program's medical record process.

7.9.3.2 The committee shall review and discuss all matters pertinent to the programs/Hospital's medical records, which should include but not be limited to, the following topics:

i. Medical records filing systems

ii. Retention and storage of medical records

iii. Storage of secondary documents

iv. Medical record information/ format

v. Identification of all types/ classifications of patients

vi. Identification of patients referred to the Hospital/ Program from other institutions

vii. Coding, indexing abstracting of diagnostic and procedural information

viii. Registration of A&E patients

ix. Standardization of Medical Records Form

x. Transcription procedures

xi. Colour coding of outpatient clinic notes

xii. Dissemination of information from the program

xiii. Discharge summaries

xiv. Microfilming

xv. Medical records folders/ forms

xvi. In-patient clinical notes

xvii. Filing of diagnostic reports in Medical Records

xviii. Medical records linkage between mother and baby

xix. Computer-generated patient details form

xx. Patient consent to clinical photography

xxi. Blood donor cards

xxii. Patient therapy cards

xxiii. Medical database and examination sheet

xxiv. Primary care and OPD case forms Reports on endoscopies, on surgical and other procedures.

7.9.4 Meetings

7.9.4.1 The Committee shall meet every three months and it shall maintain pertinent records of its proceedings and activities, which it should submit to the MDAC at regular intervals.

8. Medical Staff Meeting (Each Category of Staff)

8.1 Regular Meeting

8.1.1 Meetings of the General Medical Staff shall be held at least once every year.

8.1.2 The agenda of these meetings shall be prepared to include any items received from Head of Department (HOD) and Heads of Units and shall be circulated to all Head of Department and Heads of units at least one week in advance of the meeting.

8.1.3 Special Meetings

8.1.3.1 The Hospital Director or chairman of MDAC may call a special meeting at any time, designating the time and place of such special meeting.

8.1.3.2 Written notice, stating the place, day and hour of any special meeting of the Medical Staff shall be delivered to the Head of Department/ Head of Units. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

8.1.4 Attendance Requirements

8.1.4.1 Each member of the active Medical Staff shall be expected to attend at least one meeting every three years. Any Head of Department who is compelled to be absent from any of these meetings shall be required to promptly submit to the Hospital Director, in writing his/her reason for such absence.

8.1.5 Attendance of Non-Medical Department Representative

8.1.5.1 Representative from non-medical Departments, Human Resources, etc. shall be invited to attend meetings as and when it is deemed necessary by the Hospital Director.

9. Departmental Meetings

9.1 Regular Meeting

9.1.1 Departments shall hold regular Department and Total Quality Management Subcommittee Meetings at least monthly according to a published schedule, to review in detail and evaluate the clinical practice in and the education activities of the department.

9.2 Content of Regular Departmental Meetings

9.2.1 The Departmental Meeting shall consider all matters of concern to the proper administration, supervision, general affairs and the educational activity of the department.

9.2.2 The Total Quality Management Sub-Committee Meeting shall review the quality of patient care, shall emphasize morbidity and mortality analysis with detailed consideration of selected deaths, unimproved hospitalized patients, infections and complications, errors in diagnosis, results of treatment, analytical reports related to patient care within the hospital, and any untoward incidents or unusual occurrences which influence patient care.

9.3 Attendance

9.3.1 All members of the active Medical Staff should attend the meetings whenever their clinical commitments allow.

9.4 Right of Ex-Officio Members

9.4.1 Persons attending Departmental Meetings as ex-officio members shall have all rights and privileges of regular members, except that they not have the right to vote.

9.5 Minutes

9.5.1 Minutes of each regular and special meeting of a Department shall be prepared and shall include a record of the attendance of members and the votes taken on each matter. The Total Quality Management Sub-Committee minutes shall be signed by both the QM representative present and the Head of Department and forwarded to the Total Quality Management Unit. Each committee and Department shall maintain a permanent file of the minutes of cach meeting.

9.6 Joint Clinical Meeting

9.6.1 Joint Clinical Meeting shall be arranged between Clinical Departments e.g. Pathology, Radiology, Surgery etc. and they shall be arranged in accordance with each other's schedule.

9.7 Intra-Departmental Functional Committees / Meetings

9.7.1 The Head of Department/Heads of Divisions have the right to form/hold Intradepartmental Functional Committees/ Meetings to facilitate the organization of certain aspects of departmental/divisional activities or regulate such activities as a means of involving the Medical Staff in the management of the Department/Unit.

9.8 Attendance Requirements

9.8.1 Each member of the active Medical Staff shall be expected to attend all meetings of each Departments and Committee of which he is a member. Any member of the active Medical Staff who is compelled to be absent from such a meeting shall submit to the regular Chairman thereof, in writing, the reason for such absence.

9.8.2 The failure to attend such meetings, unless excused by the Chairman of the Committee or Department for good cause shown, shall be grounds for corrective action. The committee Chairman through the Head of Department shall report all such failures to the Chairman of the MDAC for action.

9.8.3 A member of the Medical Staff, whose patient's clinical course is scheduled for discussion at a given departmental/divisional meeting, shall be notified and shall be expected to attend such a meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the Medical Staff member shall so state and shall include a statement that his/her attendance at the meeting at which the alleged deviation is to be discussed, is mandatory.

9.8.4 Failure by a member of the Medical Staff to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused by the Chairman upon showing good cause, may result in further disciplinary action.

9.8.5 In all other cases, if the Medical Staff member shall make a timely request for postponement, supported by adequate evidence showing that his/her absence will be unavoidable, such presentation may be postponed by the Head of Department (HOD) or by the Chairman, until not later than the next regular departmental meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

10. Corrective Actions

10.1 Nature of Misconducts

10.1.1 Professional misconduct

10.1.1.1 Failure or inadequacy of performance or unacceptable behaviour arising from the exercise of medical or dental skills or professional judgment.

10.1.2 Personal Misconduct

10.1.2.1 Failure of performance or unacceptable behaviour due to factors other than those associated with the exercise of medical or dental skills.

10.1.3 Medical Malpractice

10.1.3.1 In case of unacceptable mortality or morbidity resulting from inappropriate performance, medical incompetence or proven negligence-even in the absence of patient's complaint-it is the responsibility of Director of Medical Administration to follow the instructions set by MOH regulations and the Regulation of Practicing Medical Profession in Malaysia (MMC).

10.2 Investigation

10.2.1 When a concern or issue involving professional or personal misconduct comes to the attention of the Hospital Director, he should decide either discusses the matter with the practitioner concerned or to begin an investigation. If the issue does not merit an investigation; the Hospital Director shall call the Practitioner concerned to a personal interview to discuss the matter of concern in details.

10.2.2 If the Hospital Director deems an investigation advisable, he may delegate the issues to an Investigation Committee. The Hospital Director shall promptly notify the MOH/ State Director in writing that an investigation is in progress.

10.2.3 The individual being investigated shall have an opportunity to meet with the Investigation Committee before it starts its investigation. At this meeting the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain or refuse it not less than ten (10) days before the start of the official investigation in order to

give him the opportunity to prepare his case. He should be provided as soon as possible with copies of correspondence and with statement made. He may present witnesses and/or documentary evidence to support his case.

10.2.4 The investigation Committee should hold its meetings in private and actions taken and recommendations made pursuant these By-Laws shall be treated confidentially.

10.2.5 The investigation Committee shall present its findings and recommendations for corrective actions in writing to the Hospital Director who should submit this report as follows:

a) To the State Director/MOH for his final approval and action, if the case is a personal misconduct.
b) To the Credentials & Privileging Committee if suspension or revocations of Clinical Privileges are recommended for review of the case and shall make their recommendations to the Hospital Director.

10.3 Disciplinary Actions

10.3.1 Revocation or suspension of Clinical Privileges

10.3.2 Reduction of Clinical Privileges

10.3.3 Imposed Terms of probation

10.3.4 Letter of Reprimand

10.3.5 Letter of Warning

10.3.6 Salary Deduction

10.3.7 Disciplinary Transfer

10.3.8 Termination of Employment

11. Revocation and Suspension of Clinical Privileges

11.1 Temporary Suspension of Clinical Privileges

Termination of Privileging Approval Before Expiry Date
The granting of privileging approval shall be automatically revoked if:

i. The officer is no longer serving at Hospital Tuanku Ja'afar.

ii. The officer has transferred out of the department that performs the approved procedures.

iii. The officer's legal qualification to practice has been revoked.

iv. The Hospital Privileging Committee finds the officer unfit to perform the relevant procedures due to technical reasons or concerns regarding their competency.

11.2 Communicable Disease Policy

11.2.1 A Medical Staff member who does not comply with the Hospital's communicable disease policy by filing to be tested for tuberculosis, hepatitis B, C, HIV or other identified by such policy or by failing to submit the results of such screenings, shall have his/her admitting and clinical privileges suspended immediately and automatically until compliance with the policy.

11.2.2 It shall be the duty of the Head of Department to co-operate with the Hospital Director in enforcing all such automatic suspension of clinical privileges.

11.3 Mandatory Revocation

11.3.1 Loss of License

11.3.1.1 If a Medical Staff member's license to practice his/her profession is revoked or if he/she fails to renew such license, then the admitting and clinical privileges of such Medical Staff member shall immediately and automatically be revoked.

11.3.2 Conviction of a Felony

11.3.2.1 Upon exhaustion of appeals after conviction of a Medical Staff member in any court in Malaysia, the Medical Staff member's appointment and clinical privileges are automatically revoked.

12. Appeal in The Event of Termination of Appointment / Reduction / Loss of Clinical Privileges

Appeals Against Rejected Privileging Procedures

For any privileging application that is not approved, the officer may submit a written appeal within one month of receiving the rejection decision from the Hospital Privileging Committee. The appeal will be deliberated during the subsequent Hospital Privileging Committee meeting.

If the Hospital Privileging Committee secretariat does not receive an appeal after the one-month period has expired, the case will be finalized, and the officer must submit a new privileging application.

13. Symposia Arrangement

13.1 The Department/Unit shall discuss proposed topics for Symposia before submitting their proposals to the Department of Education, Training and Research.

13.2 The Department of Health Education, Training and Research shall present proposed Symposia to the Hospital Director to review.

13.3 The Hospital Director must study the potential benefits of the Symposia the Hospital and staff and make final selection for Symposia for the coming year.

13.4 The Symposia will list under the presenting Department/Division and not individual names.

13.5 The Majority of the Organizing Committee shall be from the presenting Department/Division with one member of the Department of Health Education, Training.

13.6 The Department/Unit concerned shall be responsible for scientific issues of the symposium, including invitation of speakers and selection of topics.

13.7 The Department of Health Education, training and is responsible for the organization and coordination of symposium, including obtaining the Hospital Director Approval

13.8 Internal presentation (from the Hospital Tuanku Ja'afar Seremban) shall take priority over foreign presentations, provided they are of a comparable standard.

14. Rules & Regulation of Medical Staff

14.1 General

14.1.1 The Medical Staff shall adopt and implement Rules and Regulation as may be necessary to implement the MOH patient care standard and to prescribe the proper conduct of Medical staff activities and the level of practice required by each Medical Staff member in the Hospital. The rules and Regulation may be general in nature, applicable to the whole staff, or may be specific to a department, division, specialty or unit. MOH Standardized Rules and Regulations of Medical Staff shall relate to at least the following:

14.1.1.1 Admissions, including responsibility for admissions, priorities for admissions and handling of patient who may not be appropriate for admission, e.g. acute psychiatric patient;

14.1.1.2 Discharges, including responsibility for discharge of all patients, including patients treated in the Emergency Department;

14.1.2 Referrals: Transfer to MOH or other hospitals, including responsibility for obtaining the agreement of a responsibility physician in the receiving hospital to accept the patient;

14.1.3 Consents, including mandatory consents for limb amputation and male sterilization

14.1.4 Sick leaves and disability reports;

14.1.5 Automatic stop orders;

14.1.6 Use of any experimental or investigational drugs;

14.1.7 Coverage by specialists of the Emergency Department;

14.1.8 Required pre-operative workup, the results of which must be entered in the patient medical record prior to surgery;

14.1.9 Blood utilization, including preference of use of type-and-screen rather than type-and-cross-match orders;

14.1.10 Support of the Hospital's blood donation program.

14.2 Specific

14.2.1 All patients shall be attended by member of the Medical Staff.

14.2.2 All patients shall be the clinical responsibility of a Consultant member of staff.

14.2.3 The consultant-in-Charge must verify the admitting history and physical examination within 24 hours of the patient's admission, appending his/her dated signature to the admitting history and physical examination to signify his approval (According to MOH Standard). In the case of day care patients this may be verified prior to the patient's admission in accordance with written procedures.

14.2.4 Patients shall be discharged only on the order of the Consultant Physician or a member of the staff to whom he/she has delegated this specific responsibility for an individual patient.

14.2.5 Routine laboratory procedures to be performed on admission of the patient shall be determined by each Department and written in its Policies and Procedures.

14.2.6 Doctors' orders are to be written in the patient record. Verbal and telephones orders are only permitted under the following condition:

14.2.6.1 Verbal and telephones orders will only be given directly by a physician who quotes his medical code number.

14.2.6.2 Verbal and telephones orders will only be accepted from a resident in an emergency situation.

14.2.6.3 Verbal and telephones orders will be accepted from an intern. Verbal and telephones orders must be received by the charge nurse and as second nurse and be repeated back to the physician before being accepted.

14.2.6.4 Verbal and telephones orders will be recorded in the doctor's order sheet, with the following:

i. Date and time
ii. Name and medical code number of physicians
iii. Name of medication, dosage, route of administration, and time given
iv. Names, grades, employee number and signatures of two nurses receiving the telephone orders.

v. Verbal order medication may be dispensed for twenty-four hours administration only.
vi. Verbal and telephone orders which are not clear will not be recorded as an order to carried out. The head nurse/nursing supervisor will be notified immediately to take appropriate action.

14.2.6.5 All patient records are the property the Hospital and shall not be removed from the Hospital buildings.

14.2.6.6 Medical Staff shall not take patient records to their accommodation.

14.2.6.7 In cases of re-admission of a patient, all previous records and X-rays shall be made available to the Medical Records Department for use by the current Consultant in-Charge.

14.2.6.8 All medication brought into the Hospital by the patient shall be stored at the nurse's station and be identified by a physician.

14.2.6.9 Surgical or any other invasive procedures shall be performed only after written consent by the patient. In the case of a child or an adult unable to give this consent for medical reasons, the next of kin can give their consent. In emergencies, the government and MOH Rules and Regulations shall apply.

14.2.6.10 Except in emergencies, when the history and physical examination plus preoperative work-up are not present in the patient record at the time scheduled for operation, the operation shall be cancelled.

14.2.6.11 For the protection of the patient, the Consultant in a Department involved may request a consultation where it is his/her opinion that is beneficial.

14.2.6.12 In instances where the responsible Physician does not agree with the Consultation, he/she may

i. Seek the opinion of a second Consultant

ii. Refer the matter to the Head of Department for further advice

14.3 Medical Record Entries

Medical Record Entries shall be consistent with MOH Patient Medical Record Standard and shall specify: Identification (administrative responsibility) a record of the patient's complaint, personal history, family history, present illness, physical examination, special report (pathology, radiology etc.), provisional diagnosis, condition on discharge, discharge summary. Medical record should not be filed in the Medical Record Department until the entry for a particular episode is complete and the discharge summary prepared and signed.

14.3.1 Except in an emergency, no patient shall be admitted until a provisional diagnosis has been written in the patient record. In cases of emergency (any patient whose condition is such that any delay caused by compliance with any of these rules and regulations might prejudice the physical or mental welfare of the patient) the provisional diagnosis shall be written in the record as soon after admission as possible.

14.3.2 The Consultant in the Department to which the patient is referred on outpatient or inpatient status shall be personally responsible for the completion of a medical record for this patient. The Consultant may delegate this task to a member of his/her junior staff.

14.3.3 It is the responsibility of the Consultant-in-Charge of the patient to ensure that the patient's medical record shall be complete, including a preliminary discharge summary at the time of discharge. When this is not possible because of delays in reporting of laboratory results etc. the medical record shall be completed within 14 days after discharge. This shall be monitored by the Quality Assurance process.

14.3.4 A completed signed and date history and physical examination shall, in all cases, be recorded within 1 hour of admission of the patient. No patient shall be on a ward overnight without this being made in the patient's record.

14.3.5 New Forms for use in the patient record shall not be introduced by individual Consultant but through the Medical Record Subcommittee, which shall recommend all Forms suggested for use in the patient record.

14.3.6 Only medical and professional staff may make entries in patient medical record.

14.3.7 Patient care orders may be written by the Houseman and Residents and subsequently overseen by the responsible Physician or Dentist.

14.3.8 Only Specific grades or categories of Medical Staff (Specialist and above) are qualified to issue verbal or telephone orders.

14.3.9 Progress notes shall be written in the medical record at least daily by consutant or specialist, Medical Officer, Houseman Staff.

14.4 Continuing Medical Education

The Hospital and the Medical Staff Organization shall provide a program of continuing education for all Medical Staff members, which shall be designed to keep them informed of patient new developments in the diagnostic and therapeutic aspect of patient care to refresh them in various aspects of their basic medical education.

14.4.1 Hospital-Based Program

The Hospital-based continuing medical education program shall:

14.4.1.1 Regularly include at least weekly to monthly programs which may be held on department or Unit level.

14.4.1.2 Emphasize and encourage case discussion, clinic pathological/ clinic-radiological conferences and grand rounds

14.4.1.3 Be relevant to the type and nature of patient care delivered in the hospital.

14.4.1.4 Be related in part to the findings of Total Quality Management activities.

14.4.1.5 Include basic cardio-pulmonary resuscitation training

14.4.1.6 Be consistent with the expressed educational needs of the Medical Staff.

14.4.2 Educational Leave and Participation in Program outside the Hospital

14.4.2.1 Members of the Medical Staff may be granted paid educational leave to attend educational programs relevant to their specialty and/or to the needs of patient in MOH hospitals.

14.4.2.2 The accreditation of Medical Staff members activities should be given according to the Rules and Regulation of the Malaysia Medical Council for Continuous Postgraduate Medical Education.

15. Code of Medical Ethics

15.1 Code of Medical Ethics

The following principles are intended to aid Medical Staff individually and collectively in maintaining a high level of ethical conduct. They are standards by which a Medical Staff member may determine the propriety of his/her conduct in his/her relationship with patients, with colleagues, with member of allied positions and with the public. This should be in accordance with the General Document of the Code of Medical Ethics of MOH and Malaysia.

15.1.1 All members of the Medical Staff should adhere to the By-Laws of practicing medicine and dentistry in Malaysia.

15.1.2 The principle objective of the Medical Staff is to render service to humanity with full respect for the dignity of man. Medical and Dental Practitioners should merit their confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

15.1.3 Medical Staff should strive continually to improve medical knowledge and skills and should make available to their patients and colleagues the benefits of their professional attainments.

15.1.4 The Medical Staff should practice a method of healing founded on a scientific basis. He/she should not voluntarily associate professionally with anyone violates this principle.

15.1.5 The Medical Staff should safeguard the public and themselves against Medical Practitioners deficient in moral character or professional competence.

15.1.6 Medical Practitioners should observe all law, uphold the dignity and honour of their profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

15.1.7 Medical Staff should render service to their patients to the best of his/her ability. Having undertaken the care of patients he/she may not neglect them.

15.1.8 Medical Staff should neither receive nor pay a commission for referral of patients or the dispensing of drugs, remedies or appliances.

15.1.9 Medical Staff should seek consultation in doubtful or difficult cases or whenever it appears that the quality of medical service may be enhanced thereby.

15.1.10 Medical Staff may not reveal the confidences entrusted to him/her in the course of medical or dental attendance or the deficiencies he/she may observe in the character of patients, unless he/she is required to do so by law or unless it becomes necessary to protect the welfare of the individual or the community.

15.1.11 The honoured ideals of the medical and dental profession imply that the responsibilities of the Medical Staff extend not only to the individual but also to society where these responsibilities deserve his/her participation in activities, which have the purpose of improving the health and wellbeing of the individual and the community.

15.2 Patient's Bill of Rights

15.1.1 The patient has the right to considerate, safe and respectful care.

15.1.2 The patient has the right to obtain from the physician complete current information concerning his/ her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information shall be made available to an appropriate person on his/ her behalf. He/she the right to know, by name and professional status, the Physician responsible for coordinating his/her care.

15.1.3 The patient has the right to receive from his/her Physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the Physician responsible for the procedure and/or treatment.

15.1.4 The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/ her action.

15.1.5 The patient has the right to every consideration of his/ her privacy

concerning his/ her own medical care programme. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in his/ her care must have the permission of the patient to be present.

15.1.6 The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential.

15.1.7 The patient has the right to expect that within its capacity, a Hospital must make reasonable response to the request of an eligible patient for service.

15.1.8 The hospital must provide evaluation, service and/ or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and an explanation concerning the needs for an alternative to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient.

15.1.9 The patient has the right to obtain information as to any relationship of his/ her Hospital to other healthcare and educational institutions insofar as his/ her care is concerned. The patient has the right to obtain information as to the existence of any professional relationship among individuals, by name who are treating him/ her.

15.1.10 The patient has the right to be advised if the Hospital proposes to engage in or perform human experimentation affecting his/ her care or treatment. The patient has the right to refuse to participate in such research projects.

15.1.11 The patient has the right to expect reasonable continuity of care. He/ she has the right to know in advance what appointment times and Physicians are available and where. The patient has the right to expect the hospital will provide a mechanism whereby he/ she is informed by his/ her physician or a delegate of the physician of the patient's continuing healthcare requirement following discharge.

15.1.12 The patient has the right to change his/ her current treating Physician if he/ she can provide acceptable reasons for wishing to do so.

16. Medical Staff By- Law

16.1 Drafting and Adoption

16.1.1 The Hospital Director and Head of Department (HOD) of the Hospital is responsible for drafting and amendment of the Standardized Medical Staff By-Laws of Hospital Tuanku Ja'afar, Seremban.

16.1.2 The Standardized Medical Staff By-Laws shall be approved by the State Director Health Malaysia, and the original document shall be kept in the Director Office.

16.1.3 The approved Standard By-Laws will be distributed to all Department to make the necessary modification.

16.1.4 The concerned Department can request assistance from Hospital Director for modification of the Standard By-Law.

16.1.5 The finalized Medical Staff By-Laws of the hospital, shall be presented to the State Director for approval.

16.2 Periodic Review:

The standard Medical Staff By-Laws of Hospital Tuanku Ja'afar, Seremban (HTJS) shall be reviewed periodically every two years by the MDAC.

16.3 Amendment and Addition:

16.3.1 Any Medical Staff member may submit a proposed amendment which shall discusses the validity of the proposal.

16.3.2 If the proposed amendment is adopted by the Head of Department (HOD), he/ she shall raise the proposal to the Hospital Director to be presented at the next regular meeting of the MDAC.

16.3.3 If recommended by the MDAC to be adopted, such proposed amendment shall be presented to Hospital Director, who shall raise it to State Director.