



# MEDICAL STAFF BY-LAWS: HOSPITAL KANOWIT

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Medical Advisory Secretariat

Date: 4 March 2024

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Date: 4 March 2024

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This policy has been drafted and amended by Medical Staff Committee and Head of Units

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FIRST AMENDEMENT : 17<sup>th</sup> October 2023

SECOND AMENDEMENT : 4<sup>th</sup> March 2024

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<b>POLICY/ PROCEDURE TITLE</b>	:	STANDARDISED MEDICAL STAFF BY-LAWS
<b>PURPOSE</b>	:	To provide a platform for management, leadership, and direction to enable the effective treatment of patients and to ensure the highest standard of Professional and ethical conduct.
<b>REFERENCE</b>	:	Hospital Kanowit Policies, MOH Directives.
<b>RESPONSIBILITY OF</b>	:	Director of Hospital Kanowit
<b>APPLICABLE TO</b>	:	All Medical Staff

### **PREAMBLE:**

**WHEREAS**, this hospital provides the highest possible standard of medical services; and **WHEREAS**, 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 fulfil the hospital's obligation to its patients; and **NOW THEREFORE**, the Specialists and Medical officers practicing in hospital and related facilities hereby are established as a Medical Staff in conformity with these By-Laws.

### **INTRODUCTION:**

1. *Hospital* : Hospital Kanowit (HKWT)
2. *Policy Hospital* : A set of By-Laws governing total medical administration and operation of the program/ Hospital
3. *Medical Staff* : Includes all Medical and Allied Health Professionals appointed to the program/ Hospital

**ARTICLE 1****OBJECTIVES:**

The objectives of Hospital Kanowit Medical Staff By-Laws are:

1. To ensure that all patients 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/ program.
4. To serve as a reference for the Hospital Director, Hospital Committee or program Supervisor 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 Kanowit in accordance with ethical standards and with 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.

## **ARTICLE 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 are 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 supervise a trainee or C&P applicant

**Attending Medical Officer** – the Qualified Medical Officer 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 (e.g.: "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 Ministry of Health (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 and 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 Kanowit.

**Head of Department/Unit** – a functional title of the medical officer 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 medical officer or dentist licensed by the Malaysia Council for Health Specialties (SCHS) to practice his profession within 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.

### **ARTICLE 3**

#### **CATEGORIES AND GRADES OF THE MEDICAL STAFF:**

##### **Categories of the Medical Staff:**

There shall be four categories of the medical staff:

1. Permanent
2. Visiting
3. Temporary (Exchange)
4. 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 program/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 program/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, based on recommendation of the Credentials and Privileging Committee, to the Hospital Management Committee.

**Temporary (Exchange) Medical Staff** – status applies to Medical Practitioner appointed to the Medical Staff on an exchange program basis. The program/ 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 Allied Health staff or any other individuals who are trainees.

##### **Grades of the Medical Staff:**

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

**Head** – Shall be a medical officer or allied health staff who will be carrying out the duties as defined in his/her job Description.

**Consultant** – Shall be responsible for advising, supervising and teaching the Medical Staff in any referred cases.

**Specialist** – Shall be accountable to a named member of the Medical Staff for the care of both inpatients and outpatients and shall be responsible for advising, supervising and teaching the Medical Staff in the Department or Unit, in addition to his/her clinical responsibilities.

Trainee Titles: The job titles of Allied Health 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 State Health Department.

## **ARTICLE 4**

### **APPOINTMENT, RE-APPOINTMENT ASSIGNMENT AND CLINICAL PRIVILEGES**

#### **4.1 Applicant 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 Kanowit policies governing Credentialing and Privileging Process.

*All applications will be reviewed by the Appointed Supervisor and will be compiled by 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.*

#### **4.2 Assignment**

4.2.1 Assignment to the Hospital Kanowit staff may be granted to professionally competent Medical Practitioners who continuously meet the qualifications, standards and requirements set forth below:

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

4.2.1.2 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 program/ hospital Director that any patient treated within the program/ 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 six months as a probationary period.

*Before the end of this period, the Assigned Supervisor 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 Assigned Supervisor 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 on 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 Kanowit 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 Assigned Supervisor 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 re-assignment shall be based upon the Medical

Staff member's record of professional competence and clinical judgment in the treatment of patients, including:

- 4.3.3.1 An examination of the individual's pattern of care as demonstrated by reviews conducted by committee involved;
- 4.3.3.2 The individual's maintenance of timely, accurate and complete medical records;
- 4.3.3.3 The individual's attendance at required staff departmental meetings;
- 4.3.3.4 The individual's ethical conduct and general behaviour;
- 4.3.3.5 The individual's general application to his/ her work;
- 4.3.3.6 The individual's compliance with the Hospital Policies, Medical Staff By-Laws and Rules and Regulations;
- 4.3.3.7 The individual's physical and mental health;
- 4.3.3.8 The individual's administrative and academic activities in his/her department/division, including participation in the QM program.

#### 4.4 Clinical Privileges

4.4.1 The Head of 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 of 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 Exchange Medical Staff may be granted by the Hospital Director to a Medical Practitioner upon the basis of information made

available to him who 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, Exchange 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.

- 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.

## **ARTICLE 5**

### **EXECUTIVE MEMBERS OF THE MEDICAL STAFF**

The Executive Members of the Medical Staff shall be:

1. Hospital Director
2. Deputy Director (Clinical)
3. Head of Department/ Head of Units

#### **5.1 Qualifications of Executive Members of the Medical Staff**

The Executive Members of the Medical Staff must be members of the active Management Committee 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.

#### **5.2 Selection of Executive Members**

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

#### **5.3 Terms of office**

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

#### **5.4 Duties and Definition of Responsibilities of Executive Members**

##### **5.4.1 Medical Administration Office**

##### **Composition**

1. Director of Hospital
2. Deputy Director (Clinical)
3. Head of Unit (Human Resource)
4. Head of Unit (Financial)

##### **Responsibilities**

1. Ensure the effective management of the Clinical Departments of the Hospital/ Program 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 program.
2. Ensures medical staff's adherence to Hospital Policies, Medical Staff By-Laws, Rules and Regulations of the Medical Staff and Codes of Medical Ethics.

3. 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.
4. Facilitates the provision of the highest possible standard of medical care to patients according to MOH standard and within available resources.
5. Reports to the Hospital Director any deviation from the MOH standard in performance and quality of patient care together with appropriate proposals for improvement.
6. Acts as the representative of medical staff to the State Director and in all higher committees.
7. Ensures the development and regular update of departmental operational policies and procedures by the directors/ head of medical and paramedical departments/ division, for the purpose of regulating clinical work and enhancing the co-operative relationship between the various departments in the patient's best interest.
8. Monitors Out-patient Clinic utilization and inpatients activities of the hospital, including the length of stay, the occupation rate, and permanent bed allocation in all specialties / departments and recommends any corrective action, regarding redistribution of beds, as deemed necessary, to the Hospital Director.
9. Performs annual appraisals of all Head of Unit and heads of paramedical departments and raises his recommendations to the Hospital Director.
10. Reviews, evaluates and recommends staffing establishment changes of medical and paramedical departments to the Hospital Director or Hospital Management Team, with the objective of economically and effectively meeting the service demand.
11. Is responsible for processing government and other official clinical communications.
12. Is responsible for assignment of medical team/ escorts and other medical services offered to VIPs in and outside the hospital and for the coverage of official missions.
14. Receives, evaluates, prioritizes and presents equipment requests from Head of Department/Unit.

15. Monitors in conjunction with Administration Unit under Human Resources the recruitment process of medical and paramedical staff, including pharmacists, identifies potential severe shortage in the service provision and purposes solutions to the Hospital Director or Hospital Management Team.
16. As Chairperson of the Credentialing and Privileging Committee, he/ she 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.
17. In Conjunction with Education, Training and Research Units to promote symposia, conferences, workshops, other continuous medical education activities and research activities hospital wide.
18. Serves as Chairperson of the Medical Records Committee and to monitor the number of incomplete medical records and undertake any corrective measures.
19. Serves as Chairperson of the Medical Staff Meeting and the Credentialing & Privileging Committee and in other hospital committees, as indicated.
20. 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.
21. As area Administrator he/ she is the authorized signatory for the time sheets of all medical and paramedical departments/ division, for the advanced payment forms of all mission/ business travel claims and for the compensation of excess hour claims submitted by medical and paramedical staff.
22. Ensures the regularity of the meeting of MAC, Departmental Meetings and the meetings of the Departmental QM Teams in all medical departments, as per MOH Guidelines and Medical Staff By-Laws.
23. He/she is responsible for the development and update of the Hospital Major Disaster Plan and to ensure that all medical, nursing and paramedical staff is aware of their responsibilities and roles in the hospital response to major disaster.
24. Serves as the Principal Hospital controller of the Major Disaster Plan.

**REPORTS TO:** *Hospital Director.*

## **ARTICLE 6**

### **CLINICAL DEPARTMENTS, DIVISIONS AND UNITS**

6.1 The 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 or directly to Hospital Director.

6.2 **Organization of Clinical Departments/Units**

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

6.2.1.1 Outpatient Unit

6.2.1.2 Medicine

6.2.1.3 Obstetrics & Gynaecology

6.2.1.4 Paediatrics

6.2.1.5 Surgery

6.2.1.6 Emergency and Trauma Unit

6.2.1.6 and Others

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 MAC and approved by the Hospital 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 programs shall be coordinated through the Training Unit and Quality Unit who shall report to the Hospital Director or Head of Administration Unit

6.3 Functions of departments/ unit

- 6.3.1 Each department/ unit 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 MAC Team detailing such departmental analysis of patient care.
- 6.3.3 Develop and make recommendations for the establishment of operational policies and 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 programs of monitoring and evaluation of clinical services performed by the department/ unit in terms of conformity with such established MOH standards.
- 6.3.6 Develop and conduct programs of continuing education for Practitioners awarded Privileges in the department/ unit.
- 6.3.7 Meet monthly for the purpose of discharging the foregoing functions and of promoting the quality of care rendered by the department/ unit including, but not limited to:
- 6.3.7.1 The review of appropriate Performance Improvement reports and studies.
  - 6.3.7.2 The formulation of recommendations to the MAC Team.
- 6.3.8 Develop and conduct clinical studies and research programs.
- 6.3.9 Submit to the MAC Team minutes of its meetings and other reports concerning its activities and recommendations.

6.4 Meeting of Departments/ Unit

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

6.4.1 Each Department/ Unit of the Medical Staff shall conduct the following meetings:

6.4.1.1 Departmental or Unit Management Meeting including QM (Monthly, at least 6 per year)

6.4.1.2 Departmental or Unit Educational Meetings (CME)

6.5 Establishment or Consolidation of Departments/Unit

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

**ARTICLE 7****MEDICAL COMMITTEES****7.1 Medical Advisory Committees (MAC)****7.1.1 Composition**

The Medical Staff Committees shall be a standing Committee and shall comprise:

7.1.1.1 Deputy Director (Clinical)

7.1.1.2 All Medical Officers

7.1.1.3 Head of Department Medical, Surgical/Orthopaedic, O&G, anaesthesia, Paediatric and Emergency.

7.1.1.4 Head of Quality Unit

**7.1.2 Terms of Reference**

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

7.1.2.2 Advise the management on patient care policies.

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

7.1.2.4 Advise on medical ethics and medico-legal issues.

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

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

7.1.2.7 Duties of MAC:

- a) 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.

- b) To receive, discuss the reports and recommendations made by the Departmental Management Teams and submit its recommendations to the Hospital Management Team.
- c) To monitor QM activities, including morbidity and mortality review reports.
- d) To prioritize quality issues, e.g. proposals for improvement of patient care.
- e) To co-ordinate the activities and general policies of the various Departments/ Units.
- f) To review and decide on the Hospital Wide Policies & Procedure involving patient care and on medical intradepartmental operational policies.
- g) To ensure implementation of the approved policies of the Medical Staff in accordance with the Regulations and By-Laws of the Hospital.
- h) 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.
- i) To review the disputable issues raised by the Credentials and Privileging Committee on the professional standing of any member of Medical Staff and make the final decision.
- j) 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.
- k) To review and approve in principle all academic activities, including yearly courses, workshops and symposia programs, subject to final ratification by the Hospital Management Team.
- l) To submit the minutes of MAC meetings to the Hospital Management Team.

- m) To develop the patient's care rules and be responsible to the Head of Department (HOD) for the application of the rules once approved by the Program/ Hospital Director.

#### 7.1.2.9 Attendance

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

## 7.2 **Credentials and Privileging Committee**

The Credentials and Privileging Committee shall be a sub-committee of the Senior Medical Management Team.

### 7.2.1 Composition

7.2.1.1 The Credentials and Privileging Committee shall comprise as follows:

- a) A Chairman: Hospital Director
- b) 2 Specialists or senior Medical officers
- c) Representatives from Nursing/ AHPs according to needs.

### 7.2.1.2 Functions

The Committee shall determine and ensure that the granting of privileging is in accordance with the individual's qualification, training, competence and appropriate to the available resources.

### 7.2.1.3 Committee Meetings

- a) A quorum must be established for the committee to begin and to continue transacts business.
- b) An agenda shall accompany a notice of regularly scheduled meetings and it shall be distributed not less than (10) days prior to the meeting.
- c) Minutes will be distributed with the agenda.

- d) The committee shall meet monthly or such other frequency as decided by the committee, however, the chairperson or in his or her absence any three members, may call for an emergency meeting of the committee without notice or agenda being distributed prior to the meeting.
- e) Matters coming before the committee shall be decided by a simple majority vote of those members present and voting in favour of the motion. The chairperson has a casting vote in the case of tied vote.

Proxy voting is not permitted.

#### 7.2.1.4 Duties of the Credentials and Privileging Committee

- a) To receive and review the verification by the recruiting agent, MOH or the Department of Medical Administration of the evidence submitted by an applicant to join the Medical Staff of the Program/Hospital, before presentation to the Program Director, with positive or negative recommendations.

- b) The criteria used will be:

Education and training qualifications acquired, professional experience, current licensure to practice in the county from which the person is recruited, current references as to professional competence and ethical character (where available), health status, previous history of being called to account for professional misconduct before a disciplinary committee of any authority controlling medical practice in any country.

- c) To examine requests/ applications for:
  - Application of clinical privileges
  - Extension of contract
  - Review of clinical privileges by instructions from the
  - Promotions
- d) To report their recommendations to MAC

### 7.3 **Drug Procurement Committee**

The pharmacy & Therapeutics Committee shall be a sub-committee of the Senior Medical Management Team.

#### 7.3.1 Composition

- A Chairman: Hospital Director
- Representatives from various Departments/ Units
- Head of Department (HOD) of Pharmaceutical Services
- Representatives from Nursing and Supplies/ Logistic Services

#### 7.3.2 Purpose

##### a) **Advisory**

To recommend the adoption and assist in the formulation of broad professional policies regarding evaluation, selection, procurement, storage distribution, use, safe administration and other matters pertaining to the use of drugs in the hospital.

##### b) **Educational**

To recommend or assist in the formulation of programs designed to meet the needs of the professional staff for complete current knowledge on matters relating to drugs practices.

#### 7.3.3 Duties of the Drugs and Antibiotic Committee

The Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the program/ hospital in order to assure optimal clinical results and a minimum potential for hazard. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection procurement, storage, distribution, use, safe administration and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

- a) Recommend the addition/ deletion of drugs from the Hospital Formulary
- b) Serve as an advisory group to the Hospital Medical Staff and the Head of Department (HOD)/Unit on matters pertaining to the choice of available drugs.

- c) Make recommendations concerning drugs to be stocked on the wards and by any other services.
- d) Develop and review periodically a formulary for use in the Hospital
- e) Prevent unnecessary duplication of stocking drugs in combination having identical amounts of the same therapeutic ingredients.
- f) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.
- g) Review reported adverse reactions to drugs.
- h) Review the appropriate use of medication, drugs and appliances.
- i) To review the appropriate use of antibiotics in line with the MOH Guidelines.
- j) Established standards concerning the use and control of investigational drugs and or research in the use of recognized drugs.

#### 7.3.4 Membership:

The representatives of the Medical Departments shall be nominated by the Hospital Directors.

#### 7.3.5 Meetings

7.3.5.1 The Committee shall meet at least every 3 month and shall maintain a pertinent record of its proceedings and activities which shall be submitted to the MAC Team at regular intervals.

7.3.5.2 The Chairman has the authority to call upon ad hoc meetings required.

7.3.5.3 If a member is unable to attend, it is the responsibility of the member to send a surrogate representative. But no more than three times per calendar year.

7.3.5.4 Failure to attend the meetings more than three times per calendar year shall result in nominating a replacement.

## 7.4 **Hospital Infection and Antibiotic Control Committee (HIACC)**

The Hospital Infection and Antibiotic Control Committee shall be a sub-committee of the MAC Team.

### 7.4.1 Composition

- Chairman: Hospital Director
- Head of Laboratory Unit (Scientific Officer)
- Infectious Diseases Medical Officer
- Surgery representative
- Medicine representative
- Paediatrics representative
- Dental representative (as applicable)
- Control of Infection Nurse
- Nursing representative
- Representative from Total Quality Management

### 7.4.2 Invited Attendance

The Chairman may invite any other party to attend the meeting for discussion of specific issues as indicated by the agenda.

### 7.4.3 Purpose

The purpose of the Infection Control Committee is to develop and implement the hospital infection control program, to monitor nosocomial infections and all other infectious diseases.

### 7.4.4 Duties

The Committee shall be responsible for the surveillance of infection within the Program/ Hospital, the review and analysis of actual infections, the promotion of preventive and corrective programs designed to minimize infection hazard and the



supervision of infection control in all phases of the hospital's activities. This includes the following:

- a) Operating rooms, delivery rooms and special care units.
- b) Isolation procedures.
- c) Prevention of cross-infection through all medical equipment used for patient management or diagnosis, e.g. endoscopic equipment, ventilation apparatus, anaesthesia equipment etc.
- d) All sterilization procedures
- e) Disposal of infectious materials.
- f) Reviewing reports on current issues and the incidence of infection.
- g) Evaluating other reports involving infection risk, e.g. kitchen inspections, drinking water, etc.
- h) Introducing maintaining and when necessary, modifying policies, e.g. disinfectant, isolation, antibiotics.
- i) Provide advice on antibiotic usage based on continuing review of antimicrobial sensitivity/ resistance trends.
- j) Advising on the selection of equipment for the prevention of infection, e.g. sharp disposal boxes etc.
- k) Making recommendations to other Committees and Departments on infection control techniques.
- l) Arranging interdepartmental co-ordination and education in control of infection.
- m) Discussing any problems brought by the infection control doctor, nurse or other members of the committee.
- n) Taking responsibility for major infection control decisions.
- o) Other situations as requested by the Senior Medical Management Team.

#### 7.4.5 Meetings

7.4.5.1 The Committee shall meet at least every 3 month and shall maintain pertinent records of its proceedings and activities which should be submitted to the MAC at regular intervals.

7.4.5.2 The committee may, at the request of the Chairman, be convened at any other time, to deal with serious infection control problems or in an outbreak situation.

#### 7.4.6 Attendance

7.4.6.1 If a member is unable to attend, he/ she should send a representative, this should not occur more than three times per-calendar year.

7.4.6.2 Failure to attend meetings more than three times per-calendar shall result in nomination of a replacement.

### 7.5 **Radiation Protection Committee**

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

#### 7.5.1 Composition

The Radiation Protection Committee shall be comprised of:

- Hospital Director (Chairman)
- Radiology
- Pathology
- Nursing
- Theatres
- Occupation safety and Health Officer (OSH)

#### 7.5.2 Purpose

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.

### 7.5.3 Duties

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.

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

Review of the following:

- Accidents and incidents involving radiation.
- Personal Radiation Dose Monitoring reports.
- Radioactive Waste Management reports.
- Contamination Survey reports.

### 7.5.4 Meetings

7.5.4.1 The Committee shall meet at least every 3 month and shall maintain pertinent records of its proceedings and activities which should be submitted to the Senior Medical Management Team at regular intervals.

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

### 7.5.5 Attendance

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

7.5.5.2 Failure to attend the meeting more than three times per-calendar shall result in the nomination of a replacement.

## 7.6 **Theatre Users Committee**

Theatre Users Committee shall be a sub-committee of the Senior Medical Management Team.

### 7.6.1 Composition

- Hospital Director (Chairman)
- Medical Officer in charge of Operating Theatre & anaesthesia
- CSSD Sister/ Matron
- Chief Anaesthetic Technician or Medical Assistant
- Representative from the Quality Management Unit

### 7.6.2 Purpose

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

### 7.6.3 Duties

To supervise and manage all aspects of the following:

- Operation of Operating Theatres
- Scheduling of Operating Theatres to ensure efficiency and effectiveness
- Surgical and anaesthetic supplies
- Other business brought by individual Committee members.

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.

## 7.7 **The Blood Transfusion Committee**

### 7.7.1 The Blood Transfusion Committee shall be a sub-committee of the MAC.

- Hospital Director (Chairman)
- HOU of Blood Bank

- Chief and Senior Technicians from the Blood Bank
- Representative from:
  - Department of anaesthesia
  - Surgical Unit
  - Medical Unit
  - Obstetrics and Gynaecology Unit
  - Paediatrics Unit
  - Department of Total Quality Management
  - Nursing Administration

#### 7.7.2 Purposes

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

#### 7.7.3 Duties

- Donor recruitment and safety
- Safety of blood transfusion
- Appropriate requesting of blood
- Bloods stock for normal practice and major disaster
- Relations between blood bank and Clinical Departments and Problems arising

#### 7.7.4 Meetings

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 MAC at regular intervals.

### 7.8 **The Medical Records Committee**

7.8.1 The Medical Records Committee shall be a sub-committee of the Senior Medical Management Team.

- Hospital Director (Chairman)

- Deputy Director
- Nursing Unit
- Surgical Unit (Representative)
- Medical Unit (Representative)
- Out-patient Unit (Representative)
- Paediatrics Unit (Representative)
- Obstetrics and Gynaecology Unit (Representative)
- Medical Record Officer
- Assistant Medical Record Officer
- QM Department representative
- Medical Forms Officers

#### 7.8.2 Purpose

To ensure all medical records meet the highest standard of patient care usefulness, of historical validity (i.e. reflecting realistic documentation of medical events) and or completeness and that they are maintained in accordance with the standards established by the Medical Record Services

#### 7.8.3 Duties

The Medical Records Committee shall direct the Medical Records Officer in ensuring that the Hospital's medical record are maintained in accordance with the Medical Records Service standards and they shall make a recommendations to the Senior Medical Management Team in matters relating to the Program's medical record process. 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:

- Medical records filing systems
- Retention and storage of medical records
- Storage of secondary documents

- Medical record information/ format
- Identification of all types/ classifications of patients
- Identification of patients referred to the Hospital/ Program from other institutions
- Patient registration/ registration of newborn babies
- Coding, indexing abstracting of diagnostic and procedural information
- Registration of A&E patients
- Standardization of Medical Records Form
- Transcription procedures
- Colour coding of outpatient clinic notes
- Dissemination of information from the program
- Discharge summaries
- Medical records folders/ forms
- In-patient clinical notes
- Filing of diagnostic reports in Medical Records
- Medical records linkage between mother and baby
- Computer-generated patient details form
- Patient consent to clinical photography
- Blood donor cards
- Patient therapy cards
- Medical database and examination sheet
- Primary care and OPD case forms

- Reports on endoscopies, on surgical and other procedures.

#### 7.10.4 Meetings

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

## **ARTICLE 8**

### **MEDICAL STAFF MEETING (EACH CATEGORY OF STAFF)**

#### **8.1 Regular Meeting**

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

#### **8.2 Special Meetings**

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

8.2.2 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.

#### **8.3 Attendance Requirements**

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.

#### **8.4 Attendance of Non-Medical Department Representative**

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

## **ARTICLE 9**

### **DEPARTMENTAL/UNIT MEETINGS**

#### **9.1 Regular Meeting**

Departments/ Units shall hold regular Department and Total Quality Management Sub-Committee 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/ Unit Meetings**

9.2.1 The Departmental/ Unit 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**

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

#### **9.4 Minutes**

Minutes of each regular and special meeting of a Department/ Unit 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 each meeting.

#### **9.6 Joint Clinical Meeting**

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

### 9.7 Intra-Departmental Functional Committees/ Meetings

The Head of Department/ Heads of Unit have the right to form/ hold Intra-Departmental/Unit 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. 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 MAC for action.

9.8.2 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.

9.8.3 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.

9.8.4 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.

## **ARTICLE 10**

### **CORRECTIVE ACTIONS**

#### 10.1 **Nature of Misconducts**

##### 10.1.1 **Professional misconduct**

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**

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**

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 Deputy Director(clinical) 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 doesn't 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 Hospital Disciplinary Board or MOH 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 Hospital Disciplinary Board or 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

## **ARTICLE 11**

### **REVOCATION AND SUSPENSION OF CLINICAL PRIVILEGES**

#### **11.1 Temporary Suspension of Clinical Privileges**

Notwithstanding adherence to the general terms and Condition of Employment of the Ministry of Health Hospitals, where the professional standards or conduct any member of the Medical Staff is considered to be lower than the avowed standards of the Hospital Kanowit or where it is thought that the member of staff is acting in a professionally incompetent manner, the matter will be referred to the Hospital Director by the Head of Department/ Unit. If the Head of Department (HOD)/ Unit are in question, the Head of Department will refer the matter to the Hospital Director.

11.1.1 The Hospital Director, on the advice of the State Health Director (Medical), shall have the authority to suspend temporarily and with immediate effect all, or any portion of the clinical privileges of any member of the Medical Staff whenever the personal or professional conduct of that member of the staff:

- a) Jeopardize or will jeopardize the safety or best interest of a patient unless immediate action taken.
- b) Constitutes a wilful disregard of the Hospital Policies.

11.1.2 Such temporary suspension shall become effective immediately upon imposition.

11.1.3 Following the temporary suspension of the Medical Staff member's privileges and upon notification to the Hospital Director, an urgent ad hoc meeting of the Credentials and Privileging Committee should be convened as soon as possible, but not later than seven (7) working days after such suspension, to consider the action taken and what future action might be required.

11.1.4 Immediately following the temporary suspension, the Hospital Director shall send or cause to be sent, a special written notice (for which a signed receipt should be requested) to the suspended staff member confirming the said suspension and stating the reasons for the suspension. He/ she will be requested to appear before the Credentials and Privileging Committee for an interview at the place and on the date specified in the special written notice.

11.1.5 The affected Medical Staff member shall have the following right:

- a) To call and examine witnesses

- b) To introduce documentary evidence
- c) To cross-examine witnesses
- d) To rebut any evidence
- e) To call colleague from the same hospital to the hearing as spokesman and advisor.

11.1.6 If the Credential and Privileging Committee recommends the continuation of the suspension or other action, such recommendation shall be transmitted to the Hospital Director for final approval. Upon the program/ Hospital Director's approval, the Deputy Director (clinical) or Head of Unit will be informed of this decision and he/ she will be responsible for the implementation of such recommendation.

## 11.2 Automatic Suspension of Clinical Privileges

11.2.1 Revocation or suspension of a Medical Staff member's license to practice in any country shall automatically suspend all his clinical privileges.

11.2.2 Falsification of information or Failure to provide requested information: A Medical Staff member who makes false or incorrect statements in his application for Appointment to the Medical Staff shall be subject to temporary suspension. Failure of a Medical Staff member who is credentialed, to notify Hospitals Administration of significant changes of status as outlined on the credential's application shall be grounds for temporary suspension. If at any time a medical staff member or applicant fails to provide requested information pursuant to a formal request by the Credentials Committee, the clinical privileges shall be deemed to be temporarily suspended until the required information is provided to the satisfaction of the requesting party.

### 11.2.3 Communicable Disease Policy

A Medical Staff member who does not comply with the Hospital's communicable disease policy by failing 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. 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

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

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.

**ARTICLE 12****APPEAL IN THE EVENT OF TERMINATION OF APPOINTMENT OR REDUCTION OR LOSS OF CLINICAL PRIVILEGES**

- 12.1 If a decision has been made to terminate the appointment of a member of the Medical Staff or to reduce or suspend his/ her clinical privileges because of his/ her professional performance, the effected member shall have right to appeal.
- 12.2 Under circumstances in which an appeal is permitted the affected member, within seven (7) working days of being informed of an adverse decision, must inform the Hospital Director in writing that he/ she wishes to make an appeal and shall submit the reasons for doing so. If he/ she fails to do so within the specified time, he/ she shall be deemed to have waived his/ her right of appeal and the action shall stand.
- 12.3 Within thirty (30) calendar days after the conclusion of the appeal review, the Hospital Director shall make his final decision in the matter and shall send notice thereof through the Head of Department (HOD)/ Unit, to the affected Medical Staff member by regular internal memo. The decision of the Hospital Director immediately shall be effective and final, and not subjected to further hearing or appeal review.
- 12.4 Notwithstanding, any other provision of these by-laws, no Medical Staff member shall be entitled as a right to more than one (1) hearing and one (1) appeal review on any matter which shall have been the subject of adverse action.
- 12.5 There is no right to appeal for an individual who is not initial appointment for continuation following completion of the probationary period or for re-appointment to the Medical Staff.

**ARTICLE 13****RULES & REGULATION OF MEDICAL STAFF**

## 14.1 General

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 Admissions, including responsibility for admissions, priorities for admissions and handling of patient who may not be appropriate for admission, e.g. acute psychiatric patient;
- 14.1.2 Discharges, including responsibility for discharge of all patients, including patients treated in the Emergency Department;
- 14.1.3 Referrals;
- 14.1.4 Transfer to MOH or other hospitals, including responsibility for obtaining the agreement of a responsibility physician in the receiving hospital to accept the patient;
- 14.1.5 Consultations, including mandatory consultations for limb amputation, female or male sterilization and termination of pregnancy;
- 14.1.6 Sick leaves and disability reports;
- 14.1.7 Automatic stop orders;
- 14.1.8 Use of any experimental or investigational drugs;
- 14.1.9 Coverage by specialists of the Emergency Department;
- 14.1.10 Required pre-operative workup, the results of which must be entered in the patient medical record prior to surgery;

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

14.1.12 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 Medical Officer-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:

- a) Verbal and telephones orders will only be given directly by a medical officer who quotes his medical code number.
- b) Verbal and telephones orders will only be accepted from a Medical Officer in an emergency situation.
- c) Verbal and telephones orders will be recorded in the doctor's order sheet, with the following:
  - Date and time
  - Name and medical code number of physician
  - Name of medication, dosage, route of administration, and time given
  - Names, grades, employee number and signatures of nurse receiving the telephone orders.

- 
- Verbal order medication may be dispensed for twenty four hours administration only.
  - Verbal and telephone orders which are not clear will not be recorded as an order to carried out.
  - Doctors who gave the verbal order is obliged to attend to the patient after they are done with whatever jobs elsewhere and assess the patient concerned and document findings and plan in patient's medical record.
- 
- d) All patient records are the property the Hospital and shall not be removed from the Hospital buildings.
  - e) Medical Staff shall not take patient records to their accommodation.
  - f) 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 Medical Officer-in-Charge.
  - g) All medication brought into the Hospital by the patient shall be stored at the nurses' station and be identified by a Medical Officer.
  - h) 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.
  - i) Except in emergencies, when the history and physical examination plus pre-operative work-up are not present in the patient record at the time scheduled for operation, the operation shall be cancelled.

- j) For the protection of the patient, the Medical Officer in a Department/ Unit involved may request a consultation where it is his/ her opinion that is beneficial.
- k) In instances where the responsible Medical Officer in-charge does not agree with the Consultation/ Specialist he/ she may:
- Seek the opinion of a second Consultant
  
  
  - Refer the matter to the Hospital Director for further advice

### 14.3 Medical Record Entries

Medical Record Entries shall be consistent with MOH Patient Medical Record Standard and shall specify:

Patient's 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 Medical Officer in-charge of the Unit 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 Medical Officer in-charge of the Unit may delegate this task to a member of his/ her junior staff.
- 14.3.3 It is the responsibility of the Medical Officer in-charge of the Unit 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 3 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 6 hours 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 Medical Officer in-charge of the Unit 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 Medical Officer and subsequently overseen by the responsible Medical Officer in-charge of the Unit.
- 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 specialist or Medical Officer.

#### 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:

- a) Regularly include at least weekly to monthly programs which may be held on department or Unit level.
- b) Emphasize and encourage case discussion, clinic-pathological/ clinic-radiological conferences and grand rounds.
- c) Be relevant to the type and nature of patient care delivered in the hospital.
- d) Be related in part to the findings of Total Quality Management activities.
- e) Include basic cardio-pulmonary resuscitation training
- f) Be consistent with the expressed educational needs of the Medical Staff.

##### 14.4.2 Educational Leave and Participation in Program outside the Hospital

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. 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.

**ARTICLE 14****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 principal 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

- 15.2.1 The patient has the right to considerate, safe and respectful care.
- 15.2.2 The patient has the right to obtain from the Practitioners 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 has the right to know, by name and professional status, the Physician responsible for coordinating his/ her cares.
- 15.2.3 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 Practitioners responsible for the procedure and/ or treatment.
- 15.2.4 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.
- 15.2.5 The patient has the right to every consideration of his/ her privacy concerning his/ her own medical care program. 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.

- 15.2.6 The patient has the right to expect that all communications and records pertaining to his/ her care will be treated as confidential.
- 15.2.7 The patient has the right to expect that within its capacity, the hospital must make reasonable response to the request of an eligible patient for service.
- 15.2.8 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.
- 15.2.9 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 that was treating him/ her.
- 15.2.10 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.
- 15.2.11 The patient has the right to expect reasonably continuity of care. He/ she has the right to know in advance what appointment times and practitioners 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.
- 15.2.12 The patient has the right to change his/ her current treating practitioner if he/ she can provide acceptable reasons for wishing to do so.

**ARTICLE 15****DRAFTING, ADOPTION AND AMENDMENT TO THE MEDICAL STAFF BY-LAWS****16.1 Drafting and Adoption**

- 16.1.1 The Hospital Director and Head of Department (HOD)/ Unit of the Hospital is responsible for drafting and amendment of the Standardize Medical Staff By-Laws of Hospital Kanowit.
- 16.1.2 The Standardized Medical Staff By-Laws shall be approved by the Deputy Health State Director (Medical) and the original document shall be kept in the Director Office.
- 16.1.3 The approved Standard By-Laws will be made available to all Departments/ Unit to make the necessary modification.
- 16.1.4 The concerned Department can request assistance from Hospital Director for modification of the Standard By-Laws.
- 16.1.5 The Finalized Medical Staff By-Laws of the hospital shall be presented to the Deputy State Health Director for approval.

**16.2 Periodic Review**

The Standard Medical Staff By-Laws of Hospital Kanowit (HKWT) shall be reviewed periodically every three (3) years by the MAC.

**16.3 Amendment and Addition**

- 16.3.1 Any Medical Staff member may submit a proposed amendment which shall discuss the validity of the proposal.
- 16.3.2 If the proposed amendment is adopted by the Head of Department (HOD)/ Unit, he/ she shall raise the proposal to the Hospital Director to be presented at the next regular meeting of the MAC.
- 16.3.3 If recommended by the MAC to be adopted, such proposed amendment shall be presented to Hospital Director, who shall raise it to Deputy State Health Director (Medical).

**N.B priority for any promotion or new assignment will be given to Hospital Kanowit Medical Staff under following condition:**

1. He/ She must possess the necessary qualifications and experience.
2. He/ She must have very well past performance/ satisfactory references.

**REFERENCES:**

1. Guidelines on Credentialing and Privileging for MOH Hospitals.
2. Guidelines on Medical Records for MOH Hospitals.
3. Standardized staff Medical By-Laws – King Fahd Army Hospital Jeddah and Hospital Teluk Intan.
4. MSQH standards for Patient and Family Rights.

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