2022

MEDICAL STAFF BYLAWS

HOSPITAL UNIVERSITI TEKNOLOGI MARA (HUiTM)

UNIVERSITI TEKNOLOGI MARA

Hospital UiTM

POLICY / PROCEDURE TITLE	:	MEDICAL STAFF RULES & REGULATIONS
PURPOSE	:	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 To develop and maintain rules of self-governance and conduct of the medial staff, and to assure the quality of professional care performed within HUiTM
RESPONSIBILITY OF	:	Director of Hospital UiTM
APPLICABLE TO	:	All Medical Staff

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PREAMBLE

WHEREAS, HUiTM is a teaching hospital under the purview of Universiti Teknologi MARA and Ministry of Higher Education, Malaysia.

WHEREAS, HUiTM provides the highest possible standard of patient care, education and research.

WHEREAS, the Medical Staff of HUiTM is recognised to be responsible for the quality of medical care provided to patients and must accept this responsibility subject to the authority of the Hospital Director, *Jawatankuasa Pengurusan Hospital*, *Majlis Pengurusan Hospital*, *Majlis Eksekutif Universiti*, and *Lembaga Pengurusan Universiti*.

THEREFORE, all staff who are directly involved with the medical care and treatment of patients in the HUiTM and its related facilities hereby establish themselves as a Medical Staff in conformity with this Policy.

INTRODUCTION

Hospital: Hospital UiTM (HUiTM)

Hospital Policy: A set of guidelines governing total medical administration and operation of the Hospital.

Medical Staff: Includes all staff who are directly involved with the medical care and treatment of patients in the Hospital.

ARTICLE 1 : OBJECTIVES

1.1 The objectives of HUiTM Medical Staff Rules and Regulation are:

a) To ensure that all patients admitted or treated in any part of the HUiTM shall at all times receive quality care without regard to race, religion, colour, ancestry, economic status, educational background, marital status, disability, sex, age, national origin, or other potential discriminants.

b) To ensure the maintenance of the highest professional performance, behaviour and discipline by all Medical Staff.

c) To provide an appropriate educational and research setting that will maintain high standards and advance professional experience and knowledge of the Medical Staff.

d) To serve as a reference, when required on matters concerning the discipline of Medical Staff, the appointment and reappointment of Medical Staff and the policies relating to Medical Staff.

e) To ensure all policies and procedures in HUiTM are consistent with the Medical Staff Policy.

ARTICLE 2 : DEFINITION OF TERMS

The meanings set out in the Definition of Terms are to be attributed to such terms as used in this Policy when capitalised unless otherwise clearly required by the context in which such terms are used. Therefore, in consulting this Policy, the reader should first familiarise himself with the Definition of Terms.

When used in connection with the Medical Staff Policy, the following terms shall have the meaning given below unless otherwise specified or unless otherwise clearly required by the context in which their area used:

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.

Categories – descriptions of the types of Medical Staff according to status (e.g., “Permanent”, “Contract”, “Trainee”, “Temporary”).

Clinical Privileges – the process by which a practitioner is granted permission by the organisation to provide the medical or other patient care services within defined limits based on evaluation of the individual’s credentials and performance.

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

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

Job Description –a document which provides for the creation of a position taking into account accountability, dimension, and competency required in a specific job in an organisation.

Ethics – moral principles and values adopted by the particular profession of each Medical Practitioner and allied health professional which shall be consistent with the policies of the Hospital and laws governing the practice of medicine within HUiTM.

Head of Department – a functional title of the specialist, appointed as a professional administrator of a medical division.

Hospital Director – the person appointed by the Vice-Chancellor of UiTM as its representative at the Hospital to administer, monitor and supervise all the Hospital functions.

Human Resource Department – an organisation that performs human resource management, overseeing various employment, recruitment and employee off-boarding.

Licensure – the granting of license to practice medicine from the Malaysian Medical Council, Malaysian Dental Council, Malaysian Nursing Board, Malaysian Association of Medical Assistant, Pharmacy Board Malaysia and Allied Health Council Malaysia.

Medical Practitioner – medical and dental graduates, upon completion of internship and fully registered with the Malaysian Medical Council or Malaysian Dental Council.

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

Excerpts of Minutes of Meeting – an extract from the full minutes of meeting meant for dissemination of information among relevant Medical Staff.

Policies of the Hospital – including but not limited to Medical Staff Policy, General Hospital Operational Policy and the Hospital's directive.

Privileges – the right of a healthcare provider to provide specific medical care that is consistent with his/her training, experience, and competency.

Prerequisite – a condition which must be demonstrated to exist concerning a Medical Staff as a prior requirement for status or position.

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

Quality Assurance – 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

Quality Management – the management approach for the Hospital, centered on quality based participation of all Medical Staff, aiming at long term success through patient satisfaction and safety, benefiting the Medical Staff and society.

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 is below an acceptable standard and requiring improvement to be demonstrated.

ARTICLE 3 : CATEGORIES AND DESIGNATION OF MEDICAL STAFF

3.1. Categories of Medical Staff

There shall be five (5) categories of Medical Staff:

Permanent, Contract, Visiting, Locum and Trainee.

3.1.1. **Permanent Medical Staff** is responsible on a regular basis for the care of patients treated within HUiTM. Members of the Permanent Medical Staff shall be employees of the UiTM appointed by UiTM, shall have defined clinical privileges, shall serve on the Medical Staff Committees as appointed, and shall be required to attend the Medical Staff meeting.

3.1.2. **Contract Medical Staff** are those who are appointed by UiTM on a contractual basis.

3.1.3. **Visiting Medical Staff** are those members, not an employee of Faculty of Medicine UiTM or HUiTM, who are invited to undertake patient care, teaching or research within HUiTM. Visiting Medical Staff shall be granted the privileges based on the recommendation of the Credentialing and Privileging Committee.

3.1.4. **Locum Medical Staff** status applies to all Medical Practitioner appointed on a locum basis. Hospital Director shall decide on the approval of Locum Medical Staff, based on the recommendations by the relevant Head of Departments. However, approval by the Credentialing and Privileging Committee shall be obtained prior to any procedures by the Locum Medical Staff.

3.1.5. **Trainee Staff** shall consist of individuals who are learning and practising the skills of a particular clinical discipline e.g. Houseman, Clinical Masters Student, Post Basic Students and Fellows. Except in the case of Houseman, Trainee Staff shall be assigned to a specific Clinical Department. Houseman shall be required to meet the educational and training standards in order to acquire the full practising certificate.

3.2. Designation of Medical Staff

The job designation of Medical Staff shall be as follows:

3.2.1. Head of Department

A Consultant who carries out the duties defined in his/her Job Description.

3.2.2. Consultant

An NSR Certified Medical Practitioner after general postgraduate program and having privileges, who is responsible for the overall care of the patient and the maintenance of adequate documentation in the patient's medical record.

3.2.3. Specialist

The Medical Practitioner who has completed general postgraduate program who is not NSR certified. He/she is accountable to a named Consultant for the care of both inpatients and outpatients and shall be responsible for advising, supervising and teaching the junior Medical Staff in the Department, in addition to his/her clinical responsibilities.

3.2.4. Medical Officer

A graduate from recognised medical institutions and registered with the Malaysian Medical Council or Malaysian Dental Council.

3.2.5. Matron

A Staff Nurse who oversee and lead teams of Sister and Staff Nurses in wards and clinics, ensuring patients receiving the best care.

3.2.6. Sister

A Staff Nurse who is in charge of a ward or clinic and has managerial responsibilities for patients and Staff Nurses.

3.2.7. Staff Nurse

A person who is admitted to the general part of the Malaysian Nursing Board and who has undergone a three(3)-year Diploma or Degree in Nursing Programme at a recognised college of nursing or university and passed the Nursing Board Examination.

3.2.8. Assistant Medical Officer

A person who has undergone a three (3) year Diploma in Medical Assistant Programme at a recognised college of Medical Assistants or university and passed the Malaysian Association of Medical Assistant.

3.2.9. 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 to be beneficial to and required for the patient care within the Hospital.

3.2.10. Pharmacist

A person who is professionally qualified and licensed by the Pharmacy Board Malaysia to prepare and dispense medicinal drugs.

3.2.11. Assistant Pharmacist

Individuals who possess a Diploma in Pharmacy hired by HUiTM to work as part of a pharmacy team under the direction of a registered pharmacist.

3.2.12. *Pembantu Perawatan Kesihatan*

A person who has completed a brief healthcare training program and provide support services for Staff Nurses and Assistant Medical Officers.

3.2.13. Trainee Titles

The job titles of Medical Staff in training shall be as follows:

3.2.13.1. Houseman

The Practitioner who is undergoing pre-registration training upon graduation. The post is to be held for two years and is on a rotational basis through various departments as laid down by the Ministry of Health regulations. He/she shall be accountable to a named member of the Consultant, Specialist, Medical Officer of the Department in which he/she is rotating at the time. The Director of the Hospital shall hold administrative responsibility for the Houseman.

3.2.13.2. Clinical Masters Student/Medical Officers in Training

Practitioners who are undergoing training in recognized Postgraduate program. He/She shall be accountable to a named member of the Consultant in the Department who is his/her supervisor. Administrative responsibility for the Medical Officer in training shall be held by the Dean of Medical Faculty or Director of HUiTM, depending on the program.

3.2.13.3. Fellows

Practitioners who are already Clinical Specialist and undergoing training in subspecialty training or area of interest. He/She shall be accountable to a named member of the Consultant in the Department who is his/her supervisor. Administrative and clinical responsibility for the Specialist in training shall be held by the Dean of Medical Faculty or the Director of HUiTM, depending on the program.

ARTICLE 4 : APPOINTMENT, REAPPOINTMENT AND CLINICAL PRIVILEGES

4.1. Procedure for Application

a) Every application for an appointment as a Medical Staff will be subject to the application process set forth by the HUiTM. Applicant must submit a properly completed application online through *e-pengambilan staf UiTM*. The specific qualifications and experience requirements for categories and designation of Medical Staff are outlined in the *Pekeliling JPA* and UiTM.

b) The completed applications shall be processed in the manner indicated in UiTM policies governing. All short-listed applications will be reviewed by the Head of Department (HOD).

c) The applicants will undergo an interview process, and the successful candidates will be offered a post according to salary scheme and qualification.

d) Successful applicants must respond within 14 days of receiving the offer letter.

4.2. Appointment

a) Appointment of Medical Staff is either permanent or contract basis.

b) The letter of appointment will be issued by UiTM.

c) Contract appointment is for a period of one to three years subject to Peraturan-Peraturan Pegawai Awam (Pelantikan, Kenaikan Pangkat dan Penamatan Perkhidmatan) 2012 [P.U(A)1/2012]

4.3. Reappointment

Contract Medical Staff have to re-submit application for reappointment subject to *Pekeliling Perkhidmatan Bilangan 2 Tahun 2008 (PP2/2008) − Dasar dan Prosedur Pelantikan Secara Kontrak (Contract of Service)*

4.4. Clinical Privileges

a) The Credentialing & Privileging Committee shall recommend to the Hospital Director the Clinical Privileges to be granted to each member of the Medical Staff and act on requests for additional privileges.

b) 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 Head of Department or by the Director of a Hospital if a Head of Department being considered

c) Every member of the Medical Staff shall be entitled to exercise only those Clinical Privileges approved by the Hospital Director.

d) Granting of clinical privileges shall be awarded by the Credentialing & Privileging Committee. The Head of the Department determines the procedures that need to be credentialed. 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 Department.

e) The Credentialing and Privileging Committee shall then examine the evidence of the practitioner's character, professional competence, qualifications and ethical standing. The committee shall then determine with the relevant clinical department through the information contained in the reference given by the applicant and from all other sources available to the committee whether the applicant meets all the necessary prerequisites for the category, grade of staffs and the clinical privileges relevant to the post.

f) The Credentialing and Privileging Committee shall submit a written report of its findings with recommendations to the Hospital Director.

g) The Hospital Director may grant temporary Clinical Privileges of visiting medical staff upon the basis of the 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 to which he has been assigned and shall abide by the Medical Staff Policy.

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

i) 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 a patient's life, using every facility at the hospital necessary, including the calling of any consultation required or desirable. When an emergency no longer exists, the appropriate member of the Medical Staff shall continue the treatment of the patient.

ARTICLE 5 : JAWATANKUASA PENGURUSAN HOSPITAL

Jawatankuasa Pengurusan Hospital is the highest management committee that governs the Hospital. *Jawatankuasa Pengurusan Hospital* of the Medical Staff shall consist of:

a) Hospital Director
b) Deputy Director (Management)
c) Deputy Director (Clinical Services)
d) Deputy Director (Clinical Support Services)
e) Deputy Director (Finance)
f) Head of Quality Improvement & Patient Safety
g) Head of Research, Innovation and Industrial Linkages
h) Head of Nursing Department
i) Head of Pharmacy Department
j) Head of Infostructure Department
k) Head of Infrastructure Department
l) Any other members invited by the Hospital Director

5.1. Qualifications of *Jawatankuasa Pengurusan Hospital*

The members of the committee must be an active Consultant or the head of respective administration departments at the time of selection. In addition, members must remain 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 *Jawatankuasa Pengurusan Hospita*l Members

The members of the committee must be selected by the Hospital Director.

5.3. Terms of Office

Jawatankuasa Pengurusan Hospital shall serve according to the terms cited in the appointment.

5.3.1. Responsibilities

a) To approve the establishment of units, sections, departments, and other relevant matters for effective implementation of the functions of HUiTM.

b) To issue directives and rules related to the operations of HUiTM.

c) To ensure that approved policies, procedure, and systems are properly implemented.

d) To evaluate the status of implementation actions and to make proposals or changes of existing policies.

e) To take necessary steps in implementing strategic planning assessment, and to update according to the current requirements.

ARTICLE 6 : CLINICAL DEPARTMENTS ANG UNITS

6.1. Clinical Management Groups

The Medical Staff is organised as clinical management groups, as follows:

6.1.1 Department

The Department shall be defined as a principal independent group of Medical Staffs usually specialised and shall be managed by a Head of Department. The Department may be further comprised of Units.

6.1.2 Unit

Any facility within a department, a division or sub-specialty, designated to fulfill a certain diagnostic, therapeutic or preventive function. The Unit shall be managed by a Head, who shall report to the Head of Department.

6.2. Organisation of Clinical Departments

Medical Staff shall be organised into departments, e.g.

a) Internal Medicine
b) Obstetrics & Gynaecology
c) Paediatrics
d) Surgery
e) Emergency Medicine
f) Dentistry
g) And Others.

The Unit may become established, as deemed advisable and requested by MDAC and approved by the *Jawatankuasa Pengurusan Hospital.*

Units may establish policies and procedures consistent with overall departmental and General Hospital Operational Policies.

6.3. Functions of Departments

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

6.4.2 A report shall be submitted monthly to the Quality Department detailing such departmental analysis of patient care.

6.4.3 Develop and make recommendations for the establishment of operational policy & procedures in line with Hospital UiTM GHOP.

6.4.4 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.

6.4.5 Develop and conduct clinical studies and research programs.

6.4.6 Develop and conduct programs of monitoring and evaluation of clinical services performed by the Department in terms of conformity.

6.4.7 Develop continuing professional development and conduct program of continuing education for Medical Staff in the Department.

6.4.8 Meet regularly for the purpose of promoting the quality of care rendered by the Department including, but not limited to:

a) The review of appropriate performance improvement reports and studies.
b) The formulation of recommendations to the MDAC.

6.4. Meeting of Department

Meetings shall be conducted in accordance with the provisions of the Rules and Regulations. Each Department of the Medical Staff shall conduct the following meetings:

a) Departmental Management Meeting including Quality Assurance
b) Departmental Educational Meetings (CME)

6.5. Establishment or Consolidation of Department

At such times as it may deem appropriate, the Medical and Dental Advisory Committee (MDAC) with the approval of *Jawatankuasa Pengurusan Hospital* may establish, consolidate or dissolve Departments.

ARTICLE 7 : MEDICAL AND NURSING STUDENTS

7.1. limitations of Medical, Nursing and Assistant Medical Officer Students

a) Medical Students are not eligible for Medical Staff membership.

b) Medical and Nursing Students are generally not allowed to enter notes in the medical record.

c) Only nursing student doing management posting on their final year are allowed to write in nursing notes, under supervision.

d) Medical Students are allowed to perform certain procedures as long as it is under supervision by a member of medical staff.

e) Where the patient refused consent, medical students are not allowed to take history, perform physical examination, observe or perform any procedure.

f) Nursing Students performing procedures must be closely supervised by a Clinical Instructor or appointed Staff Nurse.

ARTICLE 8 : MEDICAL STAFF COMMITTEES

Medical Committees will include a broad representation of the Medical Staff; however, committees will consist of an appropriate number of individuals to be of an effective, yet manageable, size. Medical Staff members have a duty to actively participate in Medical Committees.

Membership on Medical Committees will be for a period of two (2) years and may be renewable.

Each Committee will keep a record of the minutes of each of its meetings, including an attendance roster. A copy of the minutes, approved by the membership and signed by the Committee Chair, will be submitted to the administrator office and will be kept on file.

Chairs of all Medical Committees will be appointed by the Hospital Director for a period of two (2) years and may be renewable.

Each committee shall make a written report to the MDAC and to other relevant committees as may be indicated.

8.1. Medical and Dental Advisory Committee (MDAC)

8.1.1 Purpose

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

b) Advise the management on patient care policies.

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

d) Advise on medical ethics and medico-legal issues.

e) Recommend remedial actions related to consultant, specialist and medical officers.

f) Review of performance of clinical disciplines through audit and Quality Assurance activities.

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

h) MDAC sub-committee chairpersons shall be responsible to report any unsettled or controversial issues from their committee to the MDAC.

i) Any other requirements set forth in the Terms of Reference of MDAC.

8.1.2 Duties

8.1.2.1. Make recommendations to the board concerning the following matters:

a) Every application for appointment of reappointment to the medical and dental staff and any request for a change in privileges;
b) The privileges to be granted to each member of the medical and dental staff;
c) The Policy respecting the medical and dental staff;
d) The revocation, suspension, or restriction of privileges of any member of the medical or dental staff; and
e) The quality of care provided in the hospital by the medical and dental staff;
f) Development and consensus of policies, procedures and standards of patient care evidence based guidelines;
g) Credentialing and privileging of clinical care providers;
h) Maintenance of professional standards and ethics;
i) Safety and performance improvement activities and risk management framework which shall include both reactive and proactive measures;
j) Clinical documentation and medical records;
k) Prevention and control of infection and antibiotic usage;
l) Drug utilisation and medication practices;
m) Use of blood and blood products;
n) Continuing professional development, training and continuing medical education;
o) Facilitation and supervision of research including the ethical aspects of research where appropriate.
p) Other duties assigned in the Terms of Reference of MDAC.

8.1.2.2. Supervise the clinical practise of medicine and dentistry in the Hospital.

8.1.2.3. Appoint the Medical Staff members of all committees.

8.1.2.4. Receive reports of the committees of the MDAC.

8.1.2.5. Approve the Medical Staff human resources plan.

8.1.2.6. Advise the JPH on any matters referred to the MDAC by the JPH including, without limitation, matters relating to medical quality management, continuing medical education, the clinical role of each department, the Medical Staff human resource plan, and appointments of physician and dentists.

8.1.2.7. Make recommendations regarding systemic or recurring quality of care issues under the rules and regulations of the Hospital.

8.1.3 Composition

8.1.3.1. The Chairman of MDAC is elected by members of the Committee through secret voting. Members of MDAC:

a) Hospital Director (Advisor)
b) Deputy Director Clinical Service
c) Deputy Director Clinical Support Service
d) Head of Quality Improvement & Patient Safety
e) Head of Medical
f) Head of General Surgery
g) Head of Psychiatry
h) Head of Radiology
i) Head of Rehabilitation Medicine
j) Head of Obstetrics & Gynaecology
k) Head of Paediatric
l) Head of Otorhinolaryngology
m) Head of Cardiothoracic
n) Head of Clinical Diagnostic Laboratory
o) Head of Orthopaedic Department
p) Head of Nephrology
q) Head of Emergency Medicine
r) Head of Anaesthesiology & Intensive Care
s) Head of Forensic
t) Head of Cardiology
u) Head of Ophthalmology
v) Head of Plastic & Reconstructive Surgery
w) Head of Oral Maxillofacial Surgery
x) Head of Primary Care Medicine
y) Head of Ambulatory Care
z) Head of Nursing

8.1.3.2. Secretariat: Quality Improvement and Patient Safety Department.

8.1.3.3. The committee will be appointed for a term of two (2) years.

8.1.3.4. The chairman of the committee will be elected from one of the among committee members thru a balloting process.

8.1.3.5. Subordinates are not allowed to represent the HOD to attend this meeting. In the event that the HOD was not able to attend the MDAC meeting, official notification needs to be made to the Chairman with a request for a special invitation to be made to the Department representative. The representative will only be present during the discussion of matters related to his/her department.

8.1.3.6. Any other representatives will attend the meeting on special invitation only.

8.1.3.7. The quorum will be 50% attendance.

8.1.4 Frequency of meeting

8.1.4.1. Frequency of meetings shall be a minimum of four (4) times per year.

8.1.4.2. Will be minuted as MDAC meeting Bil X/Year/Date.

8.1.4.3. Any other special meeting that requires committee's decision before the next MDAC

8.1.4.4. Meeting will be minuted as Special Meeting/Topic/Date.

8.2. Credentialing & Privileging Committee

8.2.1 Purpose

The purpose of this Committee is to endorse the credentials of Medical Staff for delineation of privileges in compliance with the Medical Staff Rules & Regulations, HUiTM credentialing and privileging guideline and clinical service requirements; and to review and approve credentialing policies and procedures.

8.2.2 Duties

8.2.2.1. In addition to the items described in Section 12.2, "Duties Generally", the duties of the Credentialing & Privileging Committee include, but are not limited to:

a) Act as the main committee and shall be responsible for granting final approval for the credentialing of Medical Staff, and privileging them to provide clinical service at HUiTM according to the privileges based on their specialties.
b) Upon approval, the Chairman of the Credentialing and Privileging Committee shall grant a credentialing and privileging certificate. A formal approval letter will be sent to the applicant.
c) Formulate and review policies and procedures regarding credentialing and re-credentialing and privileging in HUiTM.

8.2.3 Composition

a) The committee will be appointed for a term of two (2) years.
b) Chairman: Hospital Director.
c) Members: Deputy Director (Clinical Services), Deputy Director (Clinical Support Services), MDAC Chairman, and at least 2 Consultants.
d) Secretariat: Quality Improvement and Patient Safety Department.

8.2.4 Committee Meetings

8.2.4.1. A 2/3 quorum must be established for the committee to begin and continue a meeting.

8.2.4.2. A plan shall accompany a notice for all scheduled meetings, and it shall be distributed not less than seven (7) days prior to the meeting.

8.2.4.3. Minutes of the previous meeting will be distributed with the agenda.

8.2.4.4. The committee shall meet at least three (3) times per year.

8.3. Drug Management and Consumable Committee

8.3.1 Purpose

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.

8.3.2 Duties

8.3.2.1. Develop and review periodically a formulary or drug list for use in the hospital, it's safety and efficacy information.

8.3.2.2. Evaluate clinical data concerning new drugs or preparations requested for use in the facility.

8.3.2.3. Make recommendations regarding policies and procedures on the administration of drugs.

8.3.2.4. Review the appropriate use of medication, drugs and appliances.

8.3.2.5. Evaluating the medication management system or risk points and identifying areas to improve safety.

8.3.3 Composition

a) Chairman : Deputy Director Clinical.
b) Representatives from various Clinical Departments.
c) Head of Department of Pharmacy.
d) Representatives from Nursing.
e) Head of Finance

8.3.4 Committee Meetings

8.3.4.1. The Committee shall meet at least four times a year, and shall maintain a pertinent record of its proceedings and activities which shall be submitted to Hospital Management Committee.

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

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

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

8.4. Hospital Infection and Antibiotic Control Committee

8.4.1 Purpose

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

8.4.2 Duties

8.4.2.1. The Committee shall be responsible for the surveillance of infection within HUiTM, the review and analysis of actual infections, the promotion of preventive and corrective programmes designed to minimize infection hazards and the supervision of infection control in all phases of the hospitals' activities. This includes the following:

a) Operating rooms, delivery rooms, and special care Units.
b) Isolation procedures.
c) All sterilization procedures and disposal of infectious materials
d) Reviewing reports on current issues and the incidence of infection
e) Introducing maintaining and when necessary, modifying policies, e.g. disinfectant, isolation, antibiotics.
f) Provide advice on antibiotic usage based on continuing review of antimicrobial sensitivity/resistance trends.
g) Advising on the selection of equipment for the prevention of infection, e.g sharp disposal boxes etc.
h) Making recommendations to other Committees and Departments on infection control techniques.
i) Arranging interdepartmental co-ordination and education in control of infection.
j) Taking responsibility for major infection control decisions.

k) Reviewing nosocomial infections where there is potential for prevention or intervention to reduce the risk of future occurrence. Special focus is given to infections due to unusual pathogens and clusters

8.4.3 Composition

a) Head of Infection Prevention and Control Unit - Chairman
b) Hospital Deputy Director (Clinical) - Management Representative
c) Infectious Diseases Physician (As Applicable)
d) Clinical Microbiologist (Preferably a Consultant)
e) Consultant Physician
f) Consultant Surgeon
g) Consultant Orthopedic Surgeon
h) Consultant Paediatrics
i) Consultant Anesthesiologist / Intensivist
j) Consultant Obstetrician & Gynecologist
k) Consultant Oral Maxillofacial (OMF) / Dentistry
l) Pharmacist
m) Hospital Engineer
n) Occupational Safety and Health Officer
o) Hospital Chief Matron
p) Hospital Support Services Concessionaire
q) Secretariat: Prevention and Control of Infection Unit

8.4.4 Invited Attendance

The Chairman may invite any other party to attend the meeting for discussion of specific issues as indicated by the agenda. Nursing Matrons / Sisters of specified Clinical Areas/Unit. Head of Dietetics, Central Sterile Supplies Department (CSSD) Manager and Finance Officer will be invited to attend when deemed necessary. In addition, trainees in Medical Microbiology & Infectious Disease may be invited to attend as observers.

8.4.5 Meetings

8.4.5.1. The Committee shall meet at least twice a year and shall maintain a pertinent record of its proceedings and activities which shall be submitted to Hospital Management Committee.

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

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

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

8.5. Blood Transfusion Committee

8.5.1 Purpose

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

8.5.2 Duties

8.5.2.1. Promote best practices in the hospital based on current policies, guidelines and directives.

8.5.2.2. Proactively and regularly review transfusion practices of various disciplines in the hospital.

8.5.2.3. Promote/organize and/or conduct education and training of all clinical, laboratory and supporting staff involved in blood transfusion.

8.5.2.4. Organize regular transfusion audits on the transfusion service to ensure compliance to policies, guidelines and directives.

8.5.2.5. Ensure all transfusion adverse events such as errors in transfusion process, donor and recipient seroconversion are investigated, analysed and reported.

8.5.2.6. Monitor the hospital haemovigilance unit activities.

8.5.2.7. Implement corrective and preventive actions.

8.5.3. Composition

a) Chairman: Deputy Director (Clinical Services)

b) Representative: Medical Department, Surgical Department, CVTS, O&G, Paediatric Department, Cardiology Department, Emergency Department, Anesthesiology Department, Daycare Unit, Nursing Department.

c) Secretariat: Blood Bank

8.5.4. Meetings

The Blood Transfusion Committee shall meet at least every twice a year, or as deemed necessary by the Chairman.

8.6. Medical Record Committee

8.6.1 Purpose

The medical records committee will have oversight for the organisation's ongoing records review program, the review and approval of forms and format for the medical record, including electronic applications.

8.6.2 Duties

8.6.2.1. Establish operating policies, and standard operating procedure of Medical Records.

8.6.2.2. Check the content of patient medical records on a regular basis to ensure that the recorded clinical information is accurate, complete and detailed in accordance with the rules that have been set for the purpose of treatment, patient care assessment, learning, research and legal requirements (medico-legal).

8.6.2.3. Monitor implementation of record keeping and medical report.

8.6.2.4. Determine the forms to be used in the hospital as well as the format for data collection and medical statistics at the hospital level.

8.6.2.5. Evaluate, review and approve the use of new clinical forms or amendments to existing forms.

8.6.2.6. Monitor, evaluate and ensure the implementation of activities, quality related to medical record services meet the department's objectives.

8.6.2.7. To discuss issues relating to medical records.

8.6.2.8. To assess and monitor effectiveness of improvement programme.

8.6.2.9. Other duties related to the documentation, use, and storage of medical records.

8.6.2.10. Evaluate and monitor the quality of patient medical records and ensure quality assurance activities related to the content of patient medical records are implemented.

8.6.2.11. Collect and assign abbreviations that will be used by the clinic in recording patient information.

8.6.3. Composition

a) Chairman: Deputy Director (Clinical Support).

b) Representatives from Medical Record, Human Resource, Emergency, Internal Medicine, Anesthesiology, Orthopedic, Paediatrics O&G, Radiology, Clinical Diagnostic Lab, Nursing, IT, Pharmacy, Surgery Department, Head of Nursing Department, Head Nurse of Ward, and Head Nurse of Specialist Clinic.

c) Secretariat: Medical Records Department.

8.7. Mortality And Morbidity Committee

8.7.1 Purpose

Assist in improving patient safety and reducing medical errors of the hospital.

8.7.2 Duties

8.7.2.1. Review reported cases and to ensure data is available for trend analysis and audit.

8.7.2.2. Prioritise cases with significant learning points for discussion and in-depth analysis for meeting.

8.7.2.3. Using an agreed system or proforma for case selection.

8.7.2.4. Undertaking an initial analysis of cases to be used as part of the mortality and morbidity discussion.

8.7.3 Composition

a) Chairman: Deputy Director (Clincal Support)
b) Head of Quality Improvement and Patient Safety Department
c) Medical Consultant/Specialist
d) Surgical Consultant/Specialist
e) Consultant Anaesthesiologist
f) Secretariat: Quality Improvement and Patient Safety Department

8.7.4 Meetings

The committee should meet at least six (6) times per year.

ARTICLE 9 : MEDICAL STAFF MEETINGS

9.1 Regular Meetings

Meetings of the General Medical Staff (Townhall Meeting) shall be held at least once every year. Minutes of the meeting shall be reported to the *Jawatankuasa Pengurusan Hospital.*

9.2 Special Meetings

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

9.2.2 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.

9.3 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.

9.4 Attendance of Non-Medical Department Representatives

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

ARTICLE 10 : DEPARTMENTAL MEETINGS

10.1 **Regular Meetings**

Departments shall hold regular Department meetings at least 6 times a year, according to a published schedule, to review in detail and evaluate the clinical practice in, and the education activities of the Department.

10.2 **Content of Regular Departmental Meetings**

The departmental meeting shall consider all matters of concern to the proper administration, supervision, general affairs, quality improvement measures and the educational activity of the department.

10.3 **Attendance**

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

10.4 **Minutes**

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. Each committee and Department shall maintain a permanent file of the minutes of each meeting.

10.5 **Joint Clinical Meetings**

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

10.6 **Intra-Departmental Functional Committees/Meetings**

The Head of Department/Heads of Divisions have the right to form/hold Intra-Departmental Functional Committees/Meetings to facilitate the organisation 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.

10.7 Attendance Requirements

10.7.1 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.

10.7.2 A member of the Medical Staffs whose patients 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 state and shall include a statement that his/her attendance at the meeting at which the alleged deviation is to be discussed is mandatory.

10.7.3 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.

10.7.4 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 11 : MISCONDUCT & CORRECTIVE ACTIONS

11.1 Nature of Misconducts

11.1.1 Professional misconduct

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

11.1.2 Personal Misconduct

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

11.1.3 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 Hospital Director to follow the instructions set by Ministry of Health regulations and the Regulation of Practicing Medical Profession in Malaysia (MMC).

11.2 Inquiry Into Misconduct

11.2.1 When an issue of professional or personal misconduct comes to the attention of the Hospital Director, he or she may arrange a personal interview to discuss the matter of concern in detail.

11.2.2 If the Hospital Director deems an inquiry is advisable, he shall form an Inquiry Committee.

11.2.3 The individual being inquired shall have an opportunity to meet with the Inquiry Committee before it starts its inquiry. At this meeting, the individual shall be informed of the general nature of the evidence supporting the question being inquired and shall be invited to discuss, explain, or refute it, not less than ten (10) days before the start of the official inquiry 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.

11.2.4 The inquiry committee may hold its meetings in private and actions taken, and recommendations made pursuant to this Policy shall be treated confidentially.

11.2.5 The inquiry committee shall present its findings and recommendations for corrective actions in writing to the Hospital Director who then, may submit the report to the Credentialing & Privileging Committee if suspension or revocation of Clinical Privileges is recommended for review. In this event, the Credentialing & Privileging Committee shall submit their recommendations to the Hospital Director for further action.

11.3 Corrective Actions

11.3.1 Revocation or suspension of Clinical Privileges.
11.3.2 Reduction of Clinical Privileges
11.3.3 Imposed Terms of Probation
11.3.4 Letter of Administrative Reminder
11.3.5 Transfer to other departments/units/sections
11.3.6 Termination of contract
11.3.7 Any other actions deemed fit

11.4 Reporting to Integrity Unit, UiTM

11.4.1 If necessary, the Hospital Director may notify and/or refer the case to UiTM Integrity Unit for further action under the Statutory Bodies (Discipline and Surcharge) Act 2000 (Act 605).

11.5 Reporting To The Relevant Professional Bodies

11.5.1 If necessary, the Hospital Director may also notify and/or refer the case to the relevant professional bodies for further action.

ARTICLE 12 : REVOCATION AND SUSPENSION OF CLINICAL PRIVILEGES

12.1 Temporary Suspension of Clinical Privileges

12.1.1 Notwithstanding to the general terms and condition of employment of UiTM or HUiTM, where the professional clinical standards or conduct any member of the medical staff is considered to be lower than the avowed standards of HUiTM, 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. If the Head of department is in question, the Hospital Director will refer the matter to the Vice Chancellor.

12.1.2 The Hospital Director, on the advice of the Medical and Dental Advisory Committee, 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:

i. jeopardizes or will jeopardize the safety or best interest of a patient unless immediate action is taken.
ii. constitutes a wilful disregard of the UiTM and HUiTM policies.

12.1.3 Such temporary suspension shall become effective immediately upon imposition.

i. Following the temporary suspension of the clinical privileges of the medical staff and upon notification to the Hospital Director, an urgent ad hoc meeting of the Credentialing and Privileging Committee shall be convened, but not later than seven working days after such suspension, to consider the action taken and future corrective action.

ii. Immediately following the temporary suspension, the Hospital Director shall send or cause to be sent a 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 Medical Dental Advisory Committee for an interview at the place and on the date specified in the written notice.

iii. The affected Medical Staff member shall have the right to introduce documentary evidence and to rebut any evidence.

iv. If the Medical Dental Advisory Committee recommends the continuation of the suspension or other action, such recommendation shall be transmitted to the Hospital Director for final approval and for the implementation of such recommendation.

12.2 Automatic Suspension of Clinical Privileges

12.2.1 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 may be subject to temporary suspension.
Falsification of information involving Medical Staff member may also be subjected to consequences set forth in the Statutory Bodies (Discipline and Surcharge) Act 2000 (Act 605) and the Statutory and Local Authorities Pensions Act 1980 (Act 239), or, in cases that involves Medical Staff who is a contract, temporary, part-time, or undergoing probation, may be subjected to termination of service.

12.2.2

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 may 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 Credentialing and Privileging Committee, the clinical privileges may be deemed to be temporarily suspended until the required information is provided to the satisfaction of the requesting party.

12.3 Mandatory Revocation

12.3.1 Deregistration of License

If a Medical Staff members license to practice his/her profession is deregistered, 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.

12.3.2 Conviction of criminal act

The clinical privileges of a Medical Staff member shall be subjected to revocation if he or she is found to be convicted of any criminal act.

ARTICLE 13 : APPEAL IN THE EVENT OF REDUCTION OR LOSS OF CLINICAL PRIVILEGES

13.1 If a decision has been made to reduce or suspend medical staff clinical privileges because of his/her professional performance, the effected member shall have the right to appeal to MDAC.

13.2 Under circumstances in which an appeal is permitted, the affected member, within 2 weeks 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.

13.3 The MDAC committee shall announce their decision within 28 days of receipt of the appeal. If the decision is favourable to the applicant, the MDAC shall recommend to the Credentialing and Privileging Committee to grant credentials/privileges to the applicant. Decisions (with reasons if the appeal is refused) from the HUiTM Credentialing and Privileging Committee shall be given in writing to the appellant.

13.4 The appellant may re-apply for credentials/privileges when he/she is able to satisfactorily demonstrate clinical competence in the field involved after six months.

ARTICLE 14 : STANDARD OF CONDUCT OF MEDICAL STAFF

14.1 General

The Medical Staff shall adopt and implement relevant standard of conduct to ensure proper level of service in HUiTM. The standard of conduct may be general in nature, applicable to the whole staff, or may be specific to a department, specialty or unit.

14.2 Specific

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

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

14.2.3 The Specialist 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/her approval. 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 Inpatients, day-care patients and patients referred from Emergency Department shall be discharged only on the order of the Consultant or Medical Staff to whom he/she has delegated this specific responsibility for an individual patient.

14.2.5 Emergency Department shall maintain a list of Medical Staff members who are on-call to come to the Hospital to provide further examination or stabilising treatment for a patient with an emergency medical condition. Medical Staff who are on-call must respond to the emergency call within stipulated time and be at the Hospital within an appropriate time from when the emergency call is made. They must not refuse to come to the Hospital to provide further examination or stabilising treatment for a patient when requested to do so by an Emergency Physician.

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

14.2.7 Doctor's orders are to be written in the patient record.

14.2.8 Verbal and telephone orders for medications are not allowed except during resuscitation.

14.2.9 All patient records are the property the Hospital and shall not be removed from the Hospital premise.

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

14.2.11 All medication brought into the Hospital by the patient shall be stored at the nurses' station and be identified by a Medical Officer.

14.2.12 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 emergency, the guidelines provided by the Malaysian Medical Council shall apply.

14.2.13 Except in emergencies, when the history and physical examination plus pre-operative work-up are not present in the patient record at the times scheduled for operation, the operation shall not proceed.

14.2.14 In instances where the responsible Specialist does not agree with the Consultant, he/she may:

a) Seek the opinion of a second Consultant.
b) Refer the matter to the Head of Department for further advice.

14.3 Medical Record Entries

Medical Record Entries shall be consistent with Ministry of Health Malaysia 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 within 3 days.

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 this Policy 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 as outpatient or inpatient, 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 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 Management process.

14.3.4 A signed and dated 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 Consultant but through the Medical Record Committee, which shall recommend all forms suggested for use in the patient record.

14.3.6 Only Medical Staff may make entries in patient medical record.

14.3.7 Patient care orders may be written by the Houseman and Medical Officer and subsequently overseen by the responsible Consultant.

14.3.8 Progress notes shall be written in the medical record at least twice daily.

14.4 Continuous Medical Education

The Hospital, under the purview of respective departments shall provide a programme of continuous medical education for all Medical Staff, which shall be designed to keep them informed of pertinent new developments in the diagnostic and therapeutic aspect of patient care and to refresh them in various aspects of their basic medical education.

14.4.1 Hospital Programme

The Hospital-based continuous medical education programme shall:

a) Regularly include at least weekly to monthly programmes which may be held on Department or Unit level.
b) Emphasize and encourage case discussion, clinico-pathological/clinico- 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 Quality Assurance activities. This includes basic cardio-pulmonary resuscitation training.
e) Be consistent with the expressed educational needs of the Medical Staff

14.4.2 Educational Leave and Participation in Programs Outside the Hospital

Members of the Medical Staff may be granted paid educational leave to attend educational programmes relevant to their specialty and/or to the needs of patient in HUiTM.

ARTICLE 15 : ETHICAL CODES, ETHICAL GUIDELINES AND CODE OF PROFESSIONAL CONDUCT OF MEDICAL STAFF

15.1 **Ethical Codes, Ethical Guidelines, and Code of Professional Conduct of Medical Staff (each category of staff)**

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 members of allied positions and with the public. This should be in accordance with the relevant Ethical Codes, Ethical Guidelines, and Code of Professional Conduct of Medical Staff (each category of staff).

15.1.1 All members of the Medical Staff should adhere to the relevant ethical codes and ethical guidelines 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 that 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 laws, 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 The Duties of Medical Practitioner

Each member of the medical practitioner shall:

15.2.1 Provide professional care that meets generally accepted standards of quality, provider for continuous care for patients, and participate in all quality improvement activities of HUiTM.

15.2.2 Abide by the Medical Staff Policy and by all other hospital and departmental standards policies, rules and regulation.

15.2.3 Conform with proper attire as stipulated in the hospital dress code policy and Malaysian Medical Act.

15.2.4 Carry out functions and responsibilities as Medical Staff to the Departments, services, committee, hospital management and function of the organisation.

15.2.5 Complete in a timely manner, the medical records, discharge summary, medical reports and all other required records of patients that provide patient care services in the hospital.

ARTICLE 16 : DRAFTING, ADOPTION & AMENDMENT TO THE MEDICAL STAFF POLICY

16.1 Drafting and Adoption

16.1.1 The Hospital Director and Quality Department is responsible for drafting of the Medical Staff Policy of HUiTM.

16.1.2 The approved Medical Staff Policy of HUiTM will be distributed to all Department.

16.1.3 A concerned Department can request assistance from Hospital Director for modification of the Medical Staff Policy of HUiTM.

16.1.4 The finalised Medical Staff Policy of HUiTM shall be presented to the MDAC for approval and endorsement.

16.2 Periodic Review

The Medical Staff Policy of HUiTM shall be reviewed periodically every two years by the MDAC and Legal Office or earlier as the need arise.

16.3 Amendment and Addition

16.3.1 Any Medical Staff member may submit a proposed amendment.

16.3.2 If the proposed amendment is agreed by the Head of Department (HOD), he/she shall raise the proposal to MDAC.

16.3.3 Upon approval of MDAC, such proposed amendment shall be presented to *Jawatankuasa Pengurusan Hospital.*

This document was prepared by Quality Improvement and Patient Safety Department (QIPS), Hospital UiTM

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