The following Regulations amend and supersede the previous Regulations, based on the amended Medical Teaching Institutions Act 2015, as amended, 2019.
(Health Department Notification No. SOH-I/HD/7-53/2018 dated 21/01/2019)

MEDICAL TEACHING INSTITUTIONS

MEDICAL STAFF REGULATIONS

REGULATIONS FOR THE MEDICAL STAFF

Short title, application and commencement.

(1) These regulations will be called the Medical Teaching Institution Medical Staff Regulations, 2020.
(2) They shall come into force at once.

REGULATIONS

1. PURPOSE

The purpose of the medical staff shall be to:

a. Ensure that all patients treated at the Hospital will receive efficient, timely, appropriate care that is subjected to quality improvement practices.
b. Ensure all patients being treated for the same health problem or with the same methods/procedures receive the same level of care
c. Establish, and assure adherence to, an ethical standard of professional practice and conduct.
d. Develop and adhere to facility-specific-mechanisms for appointment to the Medical staff and delineation of clinical privileges.
e. Provide educational activities that relate to: care provided, finding of quality of care review activities and expressed need of caregivers.
f. Ensure a high level of professional performance of practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
g. Assist the Governing Board in developing and maintaining rules for Medical Staff governance and oversight.
h. Bring the dimension of Medical Staff leadership to deliberations by the Hospital and Medical Directors and the Governing Board.
i. Develop and implement continuous quality improvement activities in collaboration with the Institutional staff.

2.1 MEDICAL STAFF MEMBERSHIP

2.1.1 Membership Eligibility

a. Membership on the medical staff is a privilege extended only to, and continued for,

Medical Consultants appointed as per item 14 of the Regulations of the Act.

b. Medical staff membership is only available to physicians/dentists and others defined in para (a) above, who are granted clinical privileges at the Hospital

2.1.2 **Basic Responsibilities of Medical Staff membership**

Medical Staff members (and others with individual clinical privileges) are accountable for and have responsibility to:

a. Provide for continuous care of patients assigned to their care.

b. Observe Patient's Rights in all patient care activities.

c. Participate in continuing education, peer review, Medical Staff monitoring and evaluation.

d. Maintain standards of ethics and ethical relationships including a commitment to:

i. Abide by Pakistani law and the Institution Rules and Regulations regarding financial conflict of interest and outside professional activities for remuneration.

ii. Provide care to patients within the scope of privileges and advise the Medical Director of any change in ability to meet fully the criteria for Medical Staff membership or to carry out clinical privileges which are held.

iii. Advise the Medical Director, of any challenges or claims against professional credentials, professional competence or professional conduct within 15 calendar days of notification of such occurrences and their outcome consistent with requirements under Article 4.2 below.

iv. Contribute to, and abide by, high standards of ethics in professional practice and conduct.

e. Abide by the Act, Rules and Regulations and all other lawful standards and policies of the medical staff.

2.2 FULL-TIME MEDICAL STAFF

2.2.1 **Full time Consultant medical staff**

a. Will actively participate in the quality assurance activities required of the staff, and discharge other staff functions as may, from time to time, be required.

b. Shall, when called upon, serve as a member on designated Hospital committees.

c. Shall satisfy the requirements set forth in 7.4.1 (j) for attendance at meetings of the staff and of the department and committees of which the individual is a member.

d. Shall have rights to practice only as defined in 4.1 below.

2.2.2 **Ancillary healthcare providers**

When a non-medical or non-dental ancillary healthcare provider e.g. clinical psychologist, clinical physiotherapist, speech therapist wishes to do clinical work or research in the Hospital, an application through the Chair of the appropriate department must be made to the Medical Director on a prescribed form.

a. The Clinical Privileges Committee (CPC) shall review the application for credentialing and may be satisfied if:

i. The applicant has training, competence, and if applicable, licensure or registration to perform in the proposed area, or

ii. The activity is ordered by a member of the Medical Staff who will supervise and be responsible for the activity when defined as necessary by the Chair who may recommend to the Clinical Executive Board (CEB) that the application be granted.

b. Ancillary healthcare providers:

i. Shall have privileges which are determined on an individual basis, but these shall not include the privilege to admit patients

ii. Shall not assume responsibility for the total care of patients

iii. May serve on committees of the Clinical Executive Board

iv. Shall be responsible to the Chair of the department to which the ancillary healthcare provider is assigned for all aspects of patient care and teaching performed by or for him in the Hospital.

2.2.3 **House Staff**

a. These shall consist of residents and interns / medical officers (physicians or dentists), engaged in an approved course of training and education at the Institution, with or without compensation. Those recruited as noted in the Functions and Powers Regulations and others will be recommended for appointment by the Clinical Executive Board, or by the Medical Director on behalf of the CEB, or by the respective department's Chair, for a limited period of training subject to the regulations of the Institution.

b. No formal list of clinical privileges shall be delineated for house staff, unless they are

senior residents, designated by their department's Chair, who shall be supervising junior residents, but any procedure performed by them shall be under the appropriate supervision of a staff member privileged to perform the procedure. Evidence of supervision shall be the signature of the staff physician in the medical record.

c. House staff are expected to function in a manner which is consistent with the medical staff regulations and rules. They may serve on designated Hospital committees in non-voting capacity unless specifically included as voting members.

d. Observer

A department may permit an outside physician/student to be an observer without any patient care responsibilities.

2.3 Part-Time and Locum Consultant Staff

2.3.2 Part-Time Consultant staff

These shall consist of medical practitioners who have a defined contract for certain duties and responsibilities that are not on full time basis. These may consist of:

a. Physicians working on sessional basis (or on retainer)

b. Visiting physicians

The Visiting Consultants shall consist of Medical Practitioners whose primary professional practice base is outside the Institution but who provide expertise in the clinical teaching or research field for a defined period.

2.3.3 Locum Consultant Staff

i. A medical practitioner may be appointed to the Medical Staff on the recommendation of a Chair of a department, based on specific needs. This appointment will be for a limited period generally not to exceed 6 months and with such limited privileges as the Medical Director may specify through the Clinical Privileges Committee. All such appointments or extensions of appointments shall be reported to the next meeting of the Clinical Executive Board.

ii. Locum Staff shall be responsible to the Chair of the department or his designee to which the Medical Practitioners are assigned for all aspects of patient care or teaching performed by or for him in the Hospital.

iii. Members of the Locum Staff may attend CEB meetings but without a vote.

2.4 CONDUCT OF MEDICAL STUDENTS AT THE HOSPITAL

Medical students spend significant time within the hospital in close proximity to the patients. Hence their conduct in the hospital will be governed by the Medical Staff Regulations.

2.4.1 Student

Student means any person registered with any recognised university and/or medical institution, who is then accepted at the Institution for elective training, for a defined period of time, as an elective / observer.

2.4.2 General Conduct

In hospital, all students will present themselves with dignity befitting their status as mature, professional and responsible persons. They should maintain strict professional behaviour at all times that they are on the hospital floors or any clinical setting and in the presence of patients. Noisy discussions, joking, laughing are to be avoided in the presence of patients. There is to be no argument with any of the hospital staff. Any difference of opinion should be communicated to their relevant consultants/tutors.

2.4.3 Appearance

The Institutional identity card is to be prominently displayed at all times. Students are expected to be decently dressed in clean attire. Wearing a white coat is mandatory for students at all times on the floors, clinics, and when they are interacting with patients.

2.4.4 Academic Conduct

a. Students are to learn, and hence should diligently apply themselves to their assigned clinical work

b. They will learn the art of history taking, general/physical examination, and differential diagnosis without interfering with the normal clinical care of the patient(s) by hospital staff

c. During the learning process, all students have to give priority to patient privacy, confidentiality and convenience

d. All students must introduce themselves before any communication with the patients

e. Students observe clinical intervention by hospital staff. To personally perform any clinical intervention on the floors, outpatient area, laboratory, Radiology, or in any other clinical setting, they must be under the strict supervision and with the approval of the accredited medical staff

g. All students will respect the confidentiality of information pertaining to patients, including their records or files. Students should remember that the patients' attendants may be present

in the cafeteria, corridors, elevators, etc, and, therefore, they must exercise appropriate discretion.

h. No student will be allowed to use any information or data pertaining to patients (or the hospital) for any research, study or project, except under the supervision of a Medical Consultant.

Those failing to comply with the above maybe subjected to disciplinary action.

3.1 APPOINTMENTS

3.1.1 **MEDICAL CONSULTANTS** will be appointed as noted in article 14 of. the Regulations of the ACT,

a. Applicants for appointment to the Medical staff must submit all documents as required by these Regulations.

b. Each applicant for initial appointment and reappointment shall be required to fill-out a health questionnaire before his/her pre-employment medical examination.

c. Upon signing a contract at the time of appointment, the new medical staff member would acknowledge in writing his/her obligation to abide by the functions and powers, medical staff regulations and rules, to accept committee assignments and to fulfil departmental obligations as delineated by the Chair of the respective department.

d. Probationary period

Initial appointments are probationary. During the probationary period, professional competence, performance and conduct will be closely evaluated under applicable Institutional policies and procedures. If during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period.

e. Temporary Emergency Appointment

When there is emergent or urgent patient care need, a temporary Medical Staff appointment may be approved by the Medical Director prior to receipt of references or verification of other information and action by Clinical Privileges Committee and the Clinical Executive Board. Verification of current licensure, confirmation of possession of clinical privileges comparable to those to be granted, and a reference will be obtained prior to making such an appointment.

3.1.3 **Qualifications**

a. HOUSESTAFF: Applicants for House Staff must meet the educational requirements of the institution.

d. ANCILLARY HEALTHCARE PROVIDER Applicants shall have their qualifications assessed pursuant to the provisions set forth in Section 2 (2.2.2).

e. EXPATRIATE FACULTY are required to submit a CV to the CPC. If they intend to engage in clinical practice, the Institution will apply on their behalf to the Pakistan Medical & Dental Council (PMDC) for temporary registration to practice in Pakistan.

3.1.4 **Non-Renewal of Contract/Appointment/Change of Status**

Issues like non-renewal of contracts of Part-Time physicians, requests for change of status from Full-time to Part-time physicians or vice versa, etc. will be recommended by the Chair of the department to the Medical Director, who will then make the final decision.

3.1.5 **Agreement**

Every member of the Medical Staff shall, upon his appointment (or re-appointment) sign a statement that he has read and agrees to follow the Medical Staff Regulations and abides by the Rules of the Pakistan Medical & Dental Council.

3.1.6 **Ethics**

All members of the Medical Staff shall act in an ethical manner. They shall govern their professional conduct, financial relations and the professional care of the patients in accordance with the rules laid down by the institution and the Pakistan Medical & Dental Council.

4.1 CLINICAL PRIVILEGES

4.1.1 **General Provision**

a. All members of the Medical Staff as defined in Chapter II, who hold clinical privileges will be subjected to full credentials review at the time of initial appointment, appraisal or reappraisal for granting of clinical privileges. Credentials that are subject to change during prolonged leaves of absence may be subjected to review at the time the individual returns to duty.

b. Institutional privileges are granted for a period of three years. Privilege criteria are kept in the Medical Director’s Office.

c. Every practitioner practicing at this Hospital by virtue of medical staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those

clinical privileges specifically granted to him by the Clinical Privileges Committee.

d. Recredentialing of each Medical Staff member and any other practitioner who holds clinical privileges is required every three (03) years. Recredentialing includes a review of performance and an evaluation of the individual's physical and mental status, as well as assessment of sufficient continuing education by the individual to satisfy Medical Staff requirements. Recredentialing is initiated by the practitioner's department Chair at the time of a request by the practitioner for new and renewed clinical privileges.

e. The practitioner must adhere to the rule of General Responsibility of Care.

f. A member of the Medical Staff who desires a change of privileges shall submit his request in writing to the department's Chair with full documentation to support the change. The Chair shall forward this request with his recommendations for consideration by the Professional Standards Board.

g. Requirements and processes for requesting and granting privileges are the same for all practitioners who hold privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline or position.

h. Practitioners with clinical privileges are assigned to and have clinical privileges in one clinical department/service but may be granted clinical privileges in other clinical departments/services.

i. Exercise of clinical privileges within any service is subject to the rules of that service and to the authority of that Head of the Department.

j. When certain clinical privileges are contingent upon appointment to the faculty of affiliates, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.

4.1.2 **Application**

Every initial application for staff appointment must contain a request for specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought.

4.1.3 **Process and Requirements for Requesting Clinical Privileges**

All appointments are made on the recommendation of the Dean and/or Chair of the department. This request includes the privileges associated with the appointment. The Clinical Privileges Committee reviews and then approves, or disapproves, and make its recommendations. Such privileges are to be appropriate to the individual's qualifications and experience with any exclusion to be listed.

4.2 SUSPENSION OF PRIVILEGES

4.2.1 Whenever it is believed that a member of the Medical Staff is attempting to exceed his privileges or is temporarily incapable of providing a service that he is about to undertake, the belief shall be communicated immediately to the appropriate departmental Chair, the Medical Director, the Hospital Director, the Dean and the management committee who shall do what they consider to be in the best interests of the patients and the Hospital.

4.2.2 The Medical Director may summarily suspended privileges, on a temporary basis, pending the outcome of formal action when there is sufficient concern regarding patient safety or specific practice patterns consistent with requirements in Institutional policy for credentialing and privileging of the medical staff.

4.2.3 When recommendations regarding clinical privileges are adverse to the applicant, including but not limited to reduction and revocation, the applicant will be notified by the Medical Director with a brief statement of the basis for the action.

4.3 TEMPORARY PRIVILEGES

4.3.1 The Medical Director will have the discretion to grant temporary privileges to the medical staff of the Hospital under the following circumstances:

i. Deficiency in any one or more of the criteria required for completion of the credentialing dossier.
ii. Visiting physicians
iii. Guest physicians coming for training programs
iv. Locum consultants

4.3.2 Cases where temporary privileges have been granted by the Medical Director, will be ratified by the CPC in its next scheduled meeting.

4.4 FAIR HEARING AND APPEAL

4.4.1 Fair Hearings

4.4.1.1 Right to Hearing

a. Every effort shall be made to give any Medical staff full opportunity before an adverse action is taken against him/her. However the following actions shall entitle the applicant or named practitioner to a hearing in accordance with the procedural safeguards set forth:

i. Denial of requested delineated clinical privileges for which criteria of training or experience have been met
ii. Reduction in delineated clinical privileges
iii. Suspension of delineated clinical privileges

iv. Revocation of delineated clinical privileges

4.4.1.2 Initiation of Hearing

a. Request for hearing

i. If the Named Practitioner decides to request a hearing, such request shall be sent by an e-mail or a written application, to the Medical Director, within 15 days of receipt of the adverse recommendation by the practitioner.

ii. If the named practitioner fails, without reasonable cause, to submit a proper or timely request, it shall constitute a waiver of the right to a hearing and to any appeal to which the Named Practitioner otherwise would have been entitled by these Regulations;

iii. Failure without good cause to personally appear at a scheduled hearing shall be deemed to constitute voluntary acceptance of the recommendations involved, and waiver of the right to a hearing. If the physician waives his rights to a hearing against an adverse recommendation made by the CPC that impugned decision shall become final.

4.4.1.3 Notice of Hearing

After receipt of a request for a hearing from a Named Practitioner, an adhoc Fair Hearing Committee (FHC) from the Medical staff shall be appointed by the Medical Director, which shall schedule and arrange for a hearing and shall notify the Named Practitioner of the date, time and place by e-mail or a written notice. The hearing date shall be not more than thirty (30) days from the date that the request for hearing from the Named Practitioner was received.

4.4.1.4 Composition of Hearing Committee

A hearing shall be conducted by a Fair Hearing Committee (FHC). This committee, comprising of three (3) accredited members of the medical staff, will be constituted by the Medical Director on a case by case basis, and should be acceptable to the appellant. One of the three members would be designated as Chair for the FHC.

4.4.1.5 Conduct of Hearing

a. The Chairman FHC shall determine the order of proceedings during the hearing to assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence, rule on all motions and evidentiary matters, and maintain decorum.

b. The Named Practitioner shall be entitled to have access to any records or reports provided to the FHC.

c. A record of the hearing shall be made in the manner chosen by the FHC.

d. The personal presence of the Named Practitioner at the hearing is required. No legal practitioner shall be allowed to appear on behalf of any party during any proceedings under these Regulations.

e. If the Named Practitioner fails without good cause to appear and participate in the hearing, the Named Practitioner shall be deemed to have waived all procedural rights under this Article, with the same effect as a waiver as defined above and to have accepted the adverse decision or recommendation.

f. The Named Practitioner shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or decision lacks, totally or partially, factual basis or that such factual basis or the conclusions reached therefrom were arbitrary, unreasonable or capricious.

g. The FHC may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

h. After the hearing is closed, the FHC shall at a time deemed convenient by the FHC chair, conduct its deliberations in the absence of the Named Practitioner for whom the hearing was convened. At the completion of the FHC deliberations, the hearing shall be deemed to be finally adjourned.

i. Within three (03) business days of the final adjournment of the hearing, the FHC shall issue a written report of its findings, including a recommendation that the original adverse recommendation or decision be affirmed, rejected or modified. This report, together with the hearing record and all other documentation considered, shall be transmitted to the parties.

4.4.2 **Appeal**

4.4.2.1 Right to Appeal

a. When a decision on a matter that has been the subject of a hearing has been made and served upon the named practitioner and that decision is one listed in 4.4.1.1 (the Right to Hearing Section), the Named Practitioner shall have the right of appeal of that decision.

b. Request for Appeal by Named Practitioner:

The Named Practitioner will have ten (10) business days from the date of receipt of the decision of the FHC to request appeal of the adverse decision. This request should be delivered to the Chair CEB or his designee either in person or by e-mail / written application, and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered in making the adverse decision.

c. A Named Practitioner who fails to appeal within the time and in the manner specified waives any right to such appeal.

d. Notice of Time and Place for Hearing of Appeal:

Upon receipt of a timely request for appeal, the CEB shall schedule and arrange a hearing which shall be not more than thirty (30) days, from the date of receipt of the request for appeal request. A written notice / e-mail of the time, place and date of the hearing of appeal shall be sent to the Named Practitioner at least fifteen (15) days prior to the date scheduled for the hearing of appeal. The time for the hearing of appeal may be extended by the appellate body for good cause shown and if either party's request is made as soon as is reasonably practicable.

e. The CEB shall be the authority to conduct hearing of appeals.

4.4.2.2 Appellate Procedure

a. Nature of Proceedings

The proceedings by the appellate body (CEB) shall be based upon the record of the hearing before the FHC, that committee's report, and all subsequent results and actions thereon.

b. Written Statements

The Named Practitioner seeking the appeal may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he or she disagrees, and the reasons for such disagreement. This written statement shall be submitted to the CEB at least ten (10) business days prior to the scheduled date of the appeal, unless such time limit is waived by the CEB.

c. The Chair CEB shall determine the order of procedure during the appeal and make all required rulings.

d. Consideration of new or additional matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appeal only if permitted in the sole discretion of the CEB, following an explanation by the party requesting the consideration of such matter or evidence as to why it was not presented earlier.

e. CEB shall have all the powers granted to the hearing committee while dealing with appeals, and such additional powers as are reasonably required to discharge its

responsibilities under these Regulations.

f. Presence of Members and Vote

A majority of the CEB must be present throughout the hearing of appeal and deliberations. If a member of the appellate body is absent from any part of the proceedings, that member shall not be permitted to participate in the deliberations or the decision.

g. The CEB may recess the appellate proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

h. Action Taken

CEB, within three (03) working days of the final adjournment of its deliberations, and through a majority vote, shall make recommendations as to affirm, modify or reverse the decision made by the FHC or may remand the whole matter to FHC for re-hearing.

5.1 ORGANIZATION OF THE MEDICAL STAFF

a. The Medical Director functions as the President of the Medical Staff.

b. The Medical Staff, through its Committees, Services and Department Heads, provides counsel and assistance to the Medical Director and Hospital Director regarding all facets of the patient care services program, including continuous quality improvement, goals and plans, missions, and services offered.

c. All Full-time Consultant Medical Staff who have completed five (5) years of uninterrupted service may be eligible for membership on the Clinical Executive Board.

5.2 ARTICLE IX - CLINICAL SERVICES

5.2.1 Members of the Medical Staff shall be appointed to one or more of the following Clinical Services.

a. Department of Anaesthesiology
b. Department of Medicine and its subspecialties
c. Department of Surgery and its subspecialties
d. Department of Nuclear Medicine
e. Department of Pathology and Laboratory Medicine
f. Department of Radiology and Imaging
g. Department of Radiation Medicine
h. Department of Paediatrics and its sub-specialities

i. Department of Obstetrics and Gynaecology
j Department of Emergency Medicine
k Department of Dermatology
l. Department of Ophthalmology
m. Department of Psychiatry
n. Department of Forensic Medicine

5.2.2 **Number of Departments**

a. The Medical Director, in consultation with the Dean and the Hospital Director, and in agreement with the CEB, may from time to time close existing departments, establish additional departments, and/or establish and vary the jurisdiction of existing departments.

b. The Hospital Director, the Medical Director, and the Clinical Executive Board (CEB) after considering the recommendation of the Chair of the relevant department, may subdivide a department into sections.

5.2.3 **Characteristics**

a. Organized to carry out services under leadership of the Department Head.

b. Holds regular meeting

5.2.4 **Functions**

a. Provide for continuous quality improvement within the service including considering findings of ongoing monitoring and evaluation of quality, (including access, efficiency, effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency care absent privileges); patient satisfaction activities; risk management activities; and utilization management.

b. Assist in identification of important aspects of care for the service, identification of indicators used to monitor quality and appropriateness of important aspects of care, and evaluation of the quality and appropriateness of care.

c. Maintain records of meeting that include conclusion, recommendations, actions taken, and evaluation of actions taken.

d. Develop criteria for recommending clinical privileges for its members.

e. Develop policies and procedures to assure effective management, ethics, safety, communication and quality within the service.

5.2.5 **Selection and Appointment of Department Heads**

The Department Head will be the Chairman of the relevant department in the Medical College or his designee. Where no such Chairman or department exists in the Medical College (e.g the Blood Bank) the department Head will be appointed by the Medical Director based upon the recommendation of the CEB.

5.2.6 **Duties and Responsibilities of Department Heads**

Department Heads are responsible and accountable for:

a. All professional and administrative activities within the service including selection, orientation and continuing education of staff.

b. Monitoring and evaluating the quality of care provided in the service. This includes access, efficiency, effectiveness and appropriateness of care and treatment of patients served by the service. (Note: This monitoring and evaluation must include relevant elements such as surgical case review, drug usage evaluation, medical record review, blood/transfusion usage review, risk management, infection control, utilization review as reported by committees tasked with these functions and / or direct evaluation of the Department Head).

c. Assuring that individuals with clinical privileges competently provide service within the scope of privileges granted.

d. Assuring that individuals do not perform clinical functions for which they have not been granted privileges.

e. Recommending to the Medical Staff the criteria for clinical privileges in the service after development and approval of such criteria by the service members.

f. Recommending appointment and clinical privileges for members of the service and others requesting privileges within the service.

g. Identifying the need for new consultants, and proceeding as per Functions and Powers Regulations.

5.2.8 **Protected Research Time**

In order to ensure that Consultants are given sufficient time for scholarly activity and research, the hospital must guarantee protected time to each individual. The exact proportion of each individual's time to be set aside for research purposes will be mutually agreed by discussion between that individual, the department head and the Medical Director. Factors to be taken into consideration will include whether the individual consultant has been hired primarily for clinical function (2 sessions per week set aside for research), clinical/research (4-5 sessions of protected time per week) or primary research function (8 sessions of protected time per week).

5.3 MEDICAL STAFF MEETINGS

a. The medical staff meets as a whole on an annual basis.

b. Regular meetings are convened at the call of the chairperson. Special meetings may be convened at the call of the Hospital Director or Medical Director.

c. Medical Staff members will attend their service staff meetings and meetings of Committees of which they are members unless specifically excused by the department Head for appropriate reasons e.g. illness, leave or clinical requirements.

d. Medical staff members, or their designated alternates, will attend at least one meeting of the Medical Staff as a whole unless specially excused by the committee chairperson for appropriate reasons, e.g. illness, leave, or clinical requirements.

e. Members of the active Medical Staff are voting members.

f. Minutes of all meetings will reflect (as a minimum) attendance, issues discussed, conclusions, actions, recommendations, evaluations and follow-up.

6.1 RULES AND REGULATIONS

a) The Institution and the Board of Governors are bound by the Act and its Rules and Regulations.

b) The Medical Staff may adopt changes to these Regulations as may be necessary to implement more specifically the general principles found within these Regulations, provided they do not conflict with the Act or its Rules and other Regulations and subject to approval of the Medical and Hospital Directors and final approval of the Board of Governors. Changes to these Regulations may be adopted, amended or repealed at a general meeting or by a three-fourth vote of the CEB after the proposed changes have been brought up and discussed at a previous CEB. Such changes shall become effective when approved by the Board of Governors. Such approved changes shall become part of these Regulations.

6.2 CONSULTING PHYSICIAN

Every patient in the Hospital must at all times be the responsibility of an identified consulting physician. The identification should be recorded on the front sheet of the patient's current medical record. The patient shall be informed of the name of his/her consulting physician.

6.3 HOUSE STAFF SUPERVISION

The responsibilities accorded to members of the House Staff (Residents, Interns, Medical

Officers) must be commensurate with their ability and experience. The degree of supervision must be determined individually for each House Staff member by the consulting physician as well as the guidelines of the Hospital.

6.4 TRANSFER OF RESPONSIBILITY

Whenever the responsibility for the care of a patient is transferred from one member of the medical staff to another member of the medical staff, a written, signed notation shall be made on the patient's record. The physician to whom responsibility has been transferred shall be notified immediately and shall indicate his acceptance by making a note in the patient's record at the earliest possible time. An anticipated change or transfer of care must be communicated to the patient / family as soon as possible. Guidelines of Consultation policy approved by the CEB should also be followed.

6.5 ADMISSIONS

Only physicians who are members of the medical staff and who have admitting privileges approved by the clinical privileges committee and assigned by the Department Head may admit patients to the Hospital.

6.6 ADMISSION ASSESSMENT

The consulting physician, as defined by Hospital policies (Admission & Discharge, Assessment & Reassessment), should normally see a patient within 24 hours of admission and at that time write his own note on the patient's medical record or countersign the Resident's note.

6.7 OBLIGATORY CONSULTATIONS

The consulting physician shall have consultation with one or more appropriate members of the medical staff:

i. When requested by the patient or family
ii. When requested by the department Head or delegate

The consulting physician has a responsibility to request a consultation in situations where a patient fails to progress as expected.

6.8 MEDICAL RECORDS (MR) AND ELECTRONIC MEDICAL RECORDS (EMR)

6.8.1 Requirements

a. The attending physician shall be responsible for a written record in the electronic Medical Record (EMR) or, where this is not yet available, in hard copy (MR), of the history, physical examination and tentative diagnosis regarding each patient under his/her care within 24 hours of admission and prior to any operation, and for the completion of

medical record upon discharge of such patient. As per the "Informed Consent" policy, only the Consultants or Senior Residents are authorized to obtain the consent of the patient for treatment.

b. Medical records, EMR or MR, are confidential documents and shall not be removed from the Hospital. They may only be accessed by those physicians and personnel directly involved in the care of the individual (see also 6.8.2.c below)

c. The consulting physician may delegate to the house staff the responsibility for completion of the medical records. However, the consulting physician is accountable for the accuracy, timeliness and completion. It is the consulting physician's responsibility to sign off the patients' chart.

d. Consulting physician must ensure that:

i. Patients' history, Physical examination and orders are carried out
ii. There is a discharge summary
iii. Verbal orders and orders on the telephone are carried out
iv. He adds his own note(s) within 24 hours

e. Progress notes should be written whenever there is significant change in the patients' condition or as often as warranted by the clinical situation, and/or at least once in 24 hours.

f. Physicians are obliged to familiarize themselves with the electronic medical records system and the requisite components of the Final Notes and Operative Report.

6.8.2 **Availability of Medical Records**

a. No medical records, electronic or hard copy, are to leave the hospital premises at any time except pursuant to court order. ~~They must not be kept in areas where they are inaccessible.~~

b. When patients are transferred to another health care facility, the original record must never be sent - only copies of pertinent reports should be sent pertaining to the patients' illness.

c. Medical Records may be accessed by students, senior and junior physicians and other health care providers, etc. of the Institution, in pursuance of educational activities. Medical records may also be accessed by physicians directly involved in the care of the specific patient to whom the MR pertains. During use of medical information for educational purposes, no patient shall be identified by name without his/her consent and agreement. Unauthorized access to a MR, apart from the situations identified above, is forbidden and may be subject to disciplinary action

d. The Medical Record Department shall be informed when a MR is given to another person

or moved to another location from the place/person to whom the record was issued.

e. Photocopying or downloading of an electronic MR is prohibited, but it can be photocopied or downloaded for an educational activity by concealing the patient's identification, thereby maintaining confidentiality.

f. Reviewers are expected to return hard copies of the MR immediately if needed for patient care.

6.8.3 Chart Completion Policy

In order to ensure that health information is readily available to authorized personnel at all times, the following chart completion policy will be adhered to:

a. Electronic Medical Charts (EMR) of discharged patients will be completed within 24 hours of discharge. Where electronic charts are not yet available the hard copy charts of discharged patients will be completed and returned to the medical records department within 24 hours of discharge

b. It is the responsibility of the consulting physician to ensure that all deficiencies are completed within 10 days of discharge.

c. If a physician leaves the employment of the hospital without obtaining clearance from the medical records department, the relevant clinical chair will assume responsibility for ensuring compliance with the chart completion policy.

d. Attending/consulting Physicians are expected to complete their records before proceeding on vacation/travel and inform the Medical Records Department about their absence in writing.

e. If a physician is unable to meet his/her recording obligations, the relevant clinical chair will assume responsibility for ensuring compliance with the Chart Completion Policy.

6.8.4 Procedure

Weekly notices will be sent to physicians informing them of the number of incomplete charts pending for them in accordance with the chart completion policy and procedures.

6.9 DISCHARGES

a. Patients shall be discharged only on a written order of the attending/consulting physician or his delegate.

b. When a patient insists on leaving the Hospital against the advice of the consulting physician, he/she shall be warned of the consequences of doing so. A statement describing the

circumstances shall be entered in the patient's medical record and the patient shall be asked to acknowledge and sign the ‘Left Against medical Advice’ (LAMA) note.

6.10 DEATH CERTIFICATES

The attending/consulting physician shall ensure that a death certificate is completed for every patient who dies in the Hospital. The actual cause(s) of death must be recorded notwithstanding requests to the contrary from the deceased's family.

6.11 MEDICO-LEGAL CASES

According to the Medico-Legal Rules and Regulations of the Government, the following types of patients are subjected to this Rule:

"Every person who has reason to believe that a deceased person died;

(i) As a result of
- Violence
- Misadventure
- Negligence
- Misconduct, or
- Malpractice

(ii) By unfair means

(iii) Suddenly and unexpectedly

(iv) From disease or sickness for which he was not treated by a duly qualified medical practitioner

(v) From any cause other than disease, or

(vi) Under such circumstances as may require investigation, shall immediately notify a Coroner of the facts and circumstances relating to the death."

6.12 AUTOPSIES

The attending physician should make every effort to obtain an autopsy on all of their patients who die at the Institution. For this purpose, the next of kin or immediate family members should be approached for their consent.

6.13 NOTIFICATIONS

The attending/consulting member of the Medical Staff shall be responsible for notifying the Infection Control Nurse about all cases of communicable disease as legislated by the Ministry of Health.

6.14 OBSERVERS

a. Notwithstanding anything contained in the Regulations, a department Chair may request that a physician not already appointed to the Medical Staff be granted observer status for a specified period of time, for a specified activity or in relation to a specific` patient.

b. The request must be written and forwarded to the Medical Director, who will consider the request. If Observer status is granted, it shall be documented and circulated to all concerned staff and Departments and a special identification card issued to the incumbent.

c. Observer status does not carry with it the right of the individual to participate in any way in patient care.

6.15 CONFIDENTIALITY

Every member of the medical staff must be aware of the importance of the rights of patients to privacy and must agree to treat information related to patient care in a confidential manner and in accordance with Hospital Policy. All medical staff should familiarize themselves with policies on Patients' Rights.

6.16 PERFORMANCE APPRAISAL PROCESS

All members of the active medical staff are subject to an annual or once in two-year performance appraisal process. Amongst the various factors considered during appraisal would be clinical productivity, patient complaints, satisfaction levels, relationship with staff and patients, Medico-Legal issues, etc.

6.17 SUSPENSION OF SERVICE

If a rare occasion arises where a need is felt to temporarily discontinue a service, the Chair of the Department must obtain the approval of the Medical Director.

6.18 PRIVILEGES

a. Medical Staff may only perform such medical acts, operations and procedures for which they know themselves to be adequately trained and for which they remain competent.

b. Each member of the medical staff has an obligation to remain competent in every area for which he has privileges and to discuss his level of competence with his chief of Service.

c. In exercising his overall responsibility for the quality of medical care in his Department, the Chair of each Department shall approve only those applications for privileges which he has reason to believe are within the competence of the applicant and recommend specific exclusions if he has reason to do so.

d. At the time of appointment, it is understood that at that point, or at any time in the future, the Chair may recommend to the Clinical Privileges Committee or the Medical Director to limit the privileges of a given individual.

6.19 LICENSURE

All members of the medical staff must hold a valid license issued by the Pakistan Medical & Dental Council. This is a prerequisite for all categories of staff including ancillary healthcare providers, if they are involved in patient care. All Full-time and Non-full time faculties prior to starting their duties must ensure that they possess a current valid license to practice in Pakistan issued by the PMDC. They may seek the assistance of the Medical Director in this regard.

6.20 AMENDMENTS

a. These Regulations are reviewed at least annually, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to these Regulations, and attendance policies may be submitted to in writing to the Medical Director by any department head of the Medical Staff. Changes to the Regulations may be adopted, amended or repealed by an affirmative vote of the majority of the staff members eligible to vote and present at a general meeting, or by a three-fourth vote of the CEB after the proposed changes have been brought up and discussed at a previous CEB meeting, provided that such amendments or policies do not conflict with the Act or its Rules and other Regulations and subject to the approval of the Board of Governors. Such changes shall become effective when approved by the Board of Governors.

b. Written text to proposed significant changes are to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and will be notified of the date proposed changes will be considered.

c. All changes to these Regulations require action by both the Medical Staff/Medical Director and the Hospital Director. Neither may amend unilaterally and the final decision rests with the Board of Governors.

7.1 COMMITTEES

7.3 CLINICAL EXECUTIVE BOARD (CEB) will be structured and have the membership and functions as noted in Article 15 of the Regulations of the Act.

7.3.2 **Duties of CEB**

The Clinical Executive Board shall:

a. Meet at least once a month, and at such other times, as the Chairman may decide

b. Maintain a permanent record of its proceedings and actions

c. Make recommendations to the Medical Director concerning important matters that are

referred from various sub-committees and patient care areas

d. Provide supervision over the practice of medicine in the Hospital, including teaching and research.

e. Establish such committees as are required for the review and evaluation of all the clinical work in the Hospital;

   i. For appointment of the Chairperson of each of the committees, it establishes and ensures that each committee meets and functions as required and keeps minutes of its meetings and a record of attendance;

   ii. Receive, consider and act upon all reports from each of its established committees, including an annual report from the Chair of each committee;

f. Report as necessary to the Medical Director, concerning the practice of medicine in the Hospital in relation to professionally ethical conduct on the part of all members of the Medical Staff and to initiate such corrective measures as may be indicated;

g. Advise the Medical Director on any matter referred to the CEB.

h. Make recommendations to the Medical Director concerning clinical and general rules respecting the Medical Staff.

7.3.3 **Notice and Agenda**

Notice of a meeting of the CEB shall be sent to each member at least one week prior to the meeting by regular mail. The agenda for any meeting shall be delivered or sent by regular mail to all members of the CEB at least five days prior to the meeting.

7.3.4 **Voting**

Every member of the Clinical Executive Board shall have the right to vote. The Medical Director shall make all decisions in light of consensus of members of the CEB.

7.3.5 **Quorum**

The quorum for the transaction of business at any meeting of the Clinical Executive Board shall consist of a simple majority of members of the CEB.

7.4 STANDING COMMITTEES OF THE CLINICAL EXECUTIVE BOARD

7.4.1 **Generic Terms of Reference for all Standing Committees**

a. General Terms of reference as listed herein shall apply to all standing and ad hoc committees unless altered in their specific terms of reference. Committees will therefore

follow the process outlined in:

i. General terms of reference herein;
ii. Specific terms of reference which follow;
iii. Special requests which may emanate from the CEB

b. The Medical Director shall name the Chairperson and membership

c. Manager Quality Assurance department shall be ex officio on all committees

d. The committee, at its first meeting, shall confirm membership and appoint a Secretary who shall take Minutes and keep a record of each meeting

e. The Chair of the committee shall call meetings of the committee as required in the specific terms of reference for that committee. The committee may also meet at the request of the CEB and/or the Hospital Director.

f. The Minutes of each meeting shall be forwarded to the CEB

g. The committee shall feel free to make liaison with any other committee or group within the Hospital or beyond the Hospital which will further the business of the committee.

h. The chairman is responsible for submitting an annual written report to the CEB.

i. The Chair of the Committee will serve a term for 3 years.

j. Medical Staff members, or their designated alternates, will attend 75% of meetings of committees of which they are members unless specifically excused by the committee chairperson for appropriate reasons, e.g. illness, leave clinical requirements, etc. Committee minutes will specify members absent, alternates and members present.

7.4.2 **Standing Committees**

7.4.2.1 Preamble

a. The Standing Committees of the Clinical Executive Board may, from time to time, at its discretion, appoint ad hoc committees.

b. The general purpose of these Committees is for evaluation and advice regarding quality assurance. Recommendations from such Committees, when approved by the CEB shall be directed to the appropriate Department

c. The Medical Director shall appoint the Medical Staff members of all Standing Committees

d. Where its Terms of Reference indicate, a Standing Committee shall have access to medical records of any patient.

7.4.2.2 Names of Committees

A committee structure, staffed by a broad spectrum of health professionals and managers has been established. Such committees shall include, but not be limited to the following:

1. The Clinical Privileges Committee
2. Quality Control Committee
3. Pharmacy and Therapeutics Committee
4. Hospital Ethics Committee
5. Operating Room Committee
6. Radiation Protection Committee
7. Nutrition Support Committee
8. Intensive Care Unit Committee
9. Medical Records Committee
10. Infection Control Committee
12. Blood Bank Committee
13. Hospital Safety Committee
14. Clinical Audits Committee

These committees, their functions, and their membership shall be ensured and monitored by the CEB. Issues arising from their deliberations shall be routinely reported to the CEB for guidance and direction.

8. The Board shall form committees and draft Terms of Reference for their working and regularly supervise these committees

TERMS OF REFERENCE (TORs) OF COMMITEES

Clinical Priviliges Committee	(CPC)
Quality Control Committee	(QCC)
Pharmacy and Therapeutic Committee	(P & TC)
Hospital Ethics Committee	(HEC)
Operating Room Committee	(ORC)
Radiation Protection Committee	(RPC)
Nutrition Support Committee	(NSC)
Intensive Care Unit Committee	(ICUC)
Medical Records Committee	(MRC)
Infection Control Committee	(ICC)
Blood Bank Committee	(BUC)
Hospital Safety Committee	(HSC)
Clinical Audits Committee	(CAC)