

MEDICAL TEACHING INSTITUTIONS

MEDICAL STAFF

BY-LAWS

FOR AFFILIATED TEACHING HOSPITALS

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BYLAWS OF THE MEDICAL STAFF OF THE AFFILIATED TEACHING HOSPITAL

CHAPTER – I

INTERPRETATION

1.1 PREAMBLE

The medical staff are responsible for the quality of care delivered by its members and accountable to the Governing Board for all aspects of that care. The medical staff practicing at the Affiliated Teaching Hospital are hereby organized for governance in conformity with the bylaws and rules hereinafter stated. These Bylaws, Rules and Regulations are consistent with the Khyber Pakhtoonkhwa Medical Teaching Institutions Reform Act 2015 and its rules and regulations, and they do not create any rights or liabilities not otherwise provided for in the Act.

1.2 DEFINITIONS

- (1) **Hospital** means the affiliated teaching hospital, laboratories, clinics, imaging facilities and any other parts of the Institution where clinical work is performed.
- (2) **Institution** refers to the medical teaching Institution defined under the Khyber Pakhtunkhwa Province Medical Teaching Institutions Act IV, 2015,
- (3) **Medical staff** means all licensed physicians, and dentists who are privileged at this Hospital. The categories of medical staff, include full-time consultants, part-time consultants, honorary consultants, and attending house staff.
- (4) All privileged physicians and dentists who are serving in the capacity of consulting physicians, will retain responsibility within their areas of professional competency for the daily care and supervision of each patient in the Hospital for whom he/she is providing service, or will arrange a suitable alternative for such care and supervision.
- (5) A **Practitioner** means, unless otherwise expressly limited, a physician, surgeon, or dentist, who is fully licensed by the Pakistan Medical & Dental Council (PMDC), or otherwise granted authority, to practice in Pakistan who is applying for or exercising clinical privileges at the Hospital
- (6) **Act** refers to the Khyber Pakhtunkhwa Province Medical Teaching Institutions Act IV, 2015,

- (7) **Appointment** as used in this document refers to appointment to the medical staff.
- (8) **Rules and Regulations** refer to the specific rules and regulations pertaining to the Act
- (9) **Clinical privilege or privileges** means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical or surgical services.
- (10) **Clinical Executive Board** refers to the executive body of the medical staff, referred to in item (15) of the Regulations and is composed of the Medical Director, Medical Department heads, Director of Nursing and with the Hospital Director and QA coordinator as ex-officio members.
- (11) **Medical Director and Hospital Director** are as defined in sections 10 and 12 of the Act and Regulations, section 4 and 5.
- (12) **Bylaws** mean these Medical Staff By-laws as amended, repealed, modified or re-enacted from time to time. In addition, Bylaws means the rules established in Medical Staff Bylaws.

1.3 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.

CHAPTER – II

MEDICAL STAFF GROUPS

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.
- 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 IV of these Bylaws.
 - iv. Contribute to, and abide by, high standards of ethics in professional practice and conduct.
- e. Abide by the Medical Staff Bylaws, 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 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 bylaws, rules and regulations. 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 Bylaws.

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.

CHAPTER – III

APPOINTMENTS

3.1 APPOINTMENTS

3.1.1 **MEDICAL CONSULTANTS** will be appointed as noted in the Regulations.

- a. Applicants for appointment to the Medical staff must submit all documents as required by these Bylaws.
- 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 medical staff bylaws, rules and regulations, 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) of Chapter-II.
- 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 Hospital's By-laws 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.

CHAPTER – IV

PRIVILEGES

4.1 CLINICAL PRIVILEGES

4.1.1 General Provision (See also Regulations, Items 8 and 9)

- 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 and the Dean 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

The following definitions, in addition to those specifically provided in Chapter 1 in these Bylaws, shall apply to the provisions of this Article.

- a. "Named Practitioner" means an applicant for Medical Staff membership, or a member of the Medical Staff, against whom an adverse recommendation or decision, as defined in this Article, has been made.
- b. "Parties" means the Named practitioner who requested the hearing or appeal and the individual, body or bodies initiating or recommending the adverse action.
- c. "Hearing" means and includes hearing of named practitioner against any adverse action mentioned in this Article.
- d. "Adverse action" means an action mentioned in clause 4.4.1.1 a of this chapter

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 in this Article:
 - 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 Bylaws;

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 bylaws.
- 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 bylaws.

- 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.

CHAPTER – V

CLINICAL SERVICES AND DEPARTMENT HEADS

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 subspecialites
 - 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 Regulations item 8.

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.

CHAPTER – VI

RULES & REGULATIONS OF THE HOSPITAL

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 Bylaws as may be necessary to implement more specifically the general principles found within these Bylaws, provided they do not conflict with the Act or its Rules and Regulations and subject to approval of the Medical and Hospital Directors and final approval of the Board of Governors. Changes to these Bylaws 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 Bylaws.

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)

6.8.1 Requirements

- a. The attending physician shall be responsible for written record 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 shall not be removed from the Hospital.
- 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 atleast once in 24 hours.
- f. Physicians are obliged to familiarize themselves with the requisite components of the Final Notes and Operative Report.

6.8.2 Availability of Medical Records

- a. No medical records 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.
- 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 of a MR is prohibited, but it can be photocopied for an educational activity by concealing the patient's identification, thereby maintaining confidentiality.
- f. Reviewers are expected to return the MR immediately if needed for patient care.
- g. Please also refer to the Medical Records department's policy on 'Retention of medical records' in appendix C.

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. Charts of discharged patients will be 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 Bylaws, 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. The Bylaws, Rules and 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 the Bylaws, Rules and 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 Bylaws 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 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 the Bylaws 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.

CHAPTER – VII

CLINICAL EXECUTIVE BOARD & COMMITTEES

7.1 COMMITTEES

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

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.

SUB-COMMITTEES OF THE CLINICAL EXECUTIVE BOARD

TERMS OF REFERENCE

1. CLINICAL PRIVILEGES COMMITTEE

1. Committee Mandate

2. 1.1 The Clinical Privileges Committee (CPC) follows the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, who provides or intend to provide patient care services at the Institution (credentialing). Based on these credentials, the committee authorizes a specific scope and content of patient care services to the practitioners (privileges).The CPC also re-credentials the medical staff on an on-going basis.

2. Membership

2.1 Chair • Medical Director

2.2 Members • Head Department of Medicine
• Head Department of Surgery
• Head Department of Paediatrics
• Head Department of Anaesthesia
• Head Department of Radiology
• Head Department of Pathology
• Head Department of Radiation
• Director Nursing
• Manager Quality Assurance

2.3 Members of the CPC who are appointed by virtue of their office shall be members of the Committee for the term of their respective office.

2.4 Manager Quality Assurance will act as Secretary to the Committee.

3. Reporting Relationship

3.1 The committee shall report to the Clinical Executive Board (CEB).

4. Activities

4.1 The major activities of the Committee are credentialing, grant of privileges, re-credentialing and any other medical staff issue related to patient care.

5. Meeting Schedule

5.1 The PSB shall meet at least once every two months, or as determined by the Committee Chairperson.

QUALITY CONTROL COMMITTEE (QCC)

1. Committee Mandate

- 1.1 The QCC will have over-all responsibility for monitoring and evaluation of the clinical quality assurance activities and programs in the Hospital.
- 1.2 The Committee will identify long-standing problems or system issues that are departmental/cross-departmental and make recommendations for resolution to the Clinical Executive Board (CEB).
- 1.4 The QCC will establish an effective safety management program.

2. Membership

- 2.1 Chair • Medical Director
- 2.2 Co-chair • Head Department of Medicine
- 2.3 Members - Representatives from:
- Surgery
 - Anaesthesia
 - Paediatrics
 - Radiology
 - Pathology
 - Obstetrics/gynaecology
 - Psychiatry
 - Director Nursing
 - Manager Quality Assurance
 - Quality Assurance Officer
 - On need basis, representatives from other departments / Committees would be invited for their feedback.
- 2.4 The Chair will serve for three years, while membership tenure will be for two years.
- 2.5 The Quality Assurance Officer will act as Secretary to the Committee.

3. Reporting Relationship

- 3.1 The committee shall report to the Medical Director and the Clinical Executive Board (CEB).

4. Activities

4.1

- 4.1.1 Ensure that appropriate processes of quality improvement activities are in place in all departments. Each department, in collaboration with QA department, will present regular reports and/or up-dates on the Quality assurance processes and mechanisms in place to:
 - 4.1.1.1 Monitor and evaluate the quality of patient care
 - 4.1.1.2 Monitor the clinical performances of individuals with delineated privileges
 - 4.1.1.3 Identify and address opportunities for improvement and resolve important problems in Patient care.
- 4.1.2 Discuss these reports/updates and send recommendations to the Clinical Executive Board (CEB).
- 4.1.3 Review practice standards and criteria defined by all clinical departments.
- 4.1.4 Set and monitor hospital-wide clinical quality assurance indicators.
- 4.1.5 Identify trends against set standards in department/s and recommend appropriate corrective actions to the Clinical Executive Board (CEB).
- 4.1.6 Submit monthly minutes to the Clinical Executive Board (CEB) listing, activities, identified problems with recommendations, proposed solutions and alternative options.
- 4.1.7 Review and coordinate QA activity reports and statistics received from all QC representatives and Joint Staff Sub-Committees for presentation to the Medical Director.

5. Meeting Schedule

- 5.1 The QC shall meet at least once monthly, or as determined by the Committee Chairperson.

PHARMACY & THERAPEUTICS COMMITTEE (P & T COMMITTEE)

The effective treatment of patients in a hospital is often dependent upon the effective use of drugs. The wide varieties of drugs available and complexities surrounding their effective use require that a mandatory and sound program of drug usage be developed within the Hospital.

The program should provide for the objective evaluation, selection and use of medicinal agents in the hospital and ought to be the basis of rational drug therapy. The concept of a hospital formulary is a method of providing such a program.

The hospital formulary is a compilation of pharmaceuticals reflecting the current clinical judgements of the medical and pharmacy staff and is subject to continuous revision, and update.

The hospital formulary system is a method whereby the medical staff working through the Pharmacy and Therapeutic Committee evaluates, appraises and selects dosage forms, those that are considered most useful to and effective patient care.

The formulary system provides for procuring, prescribing, dispensing and administration of drugs under their generic names. It is based upon approval by the medical staff, the concurrence of individual staff members and recommendations of the Pharmacy and Therapeutic Committee.

An effective way of ensuring rational drug therapy and continuously updated pharmacy services is by employing the formulary system functioning under the supervision of the Pharmacy and Therapeutic Committee. The establishment of a P & T Committee is a measure, which supports and enhances the principle of self-regulation in the area of high drug standards.

1. Committee Mandate

- 1.1 The Pharmacy and Therapeutic Committee is an advisory group composed chiefly of physicians and pharmacists and representatives from various departments of the hospital.
- 1.2 The committee serves as the organizational line of communication between the Medical Staff and the Pharmacy Department.
- 1.3 The committee is a policy recommending body to the medical staff and to hospital administration on all matters related to the therapeutic use of drugs within the hospital and its clinics.

2. Membership

- 2.1 Chair •Representative from Internal Medicine
- 2.2 Members – representatives from:
 - Obstetrics/gynaecology
 - Surgery
 - Paediatrics
 - Anaesthesia
 - Ophthalmology
 - Psychiatry
 - Nursing
 - Manager Pharmacy
 - Manager MMD
 - Manager Quality Assurance
- 2.3 The Chair will serve for three years, while membership tenure will be for two years.
- 2.4 Manager Pharmacy will act as Secretary to the Committee.

3. Reporting Relationship

3.1 The committee shall report to the Medical Director and the Hospital Director.

4. Activities

4.1 The primary purposes of the Pharmacy and Therapeutic Committee are:

4.1.1 Administrative

The committee shall establish administrative policies regarding evaluation, procurement, distribution, safe use practices and other matters pertinent to drugs in the hospital and clinics.

4.1.2 Educational

The committee shall recommend and assist in the formulation of programs designed to meet the needs of the professional staff (doctors, pharmacists and nurses) for complete current knowledge on matters related to drugs and drug practices.

4.1.3 Advisory

The committee shall serve in an advisory capacity to the medical staff and other groups in the establishment of broad policies relating to drug usage in patient care and hospital procedures.

4.2 P&T Committee shall develop and approve a Drug Formulary for the hospital and provide for its continual revision and update.

4.3 P&T Committee shall evaluate suggestions of drugs/agents proposed for addition to/deletion from the hospital formulary.

4.4 P&T Committee shall minimize duplication of the same basic drug type.

4.5 P&T Committee shall recommend additions and deletions of drug stocked in the pharmacy.

4.6 The Committee shall make and/or consider recommendations concerning drugs to be stocked in hospital patient units or services.

4.7 P&T Committee shall study problems related to the distribution and administration of medication.

4.8 P&T Committee shall recommend policies regarding the safe use of drugs in the hospital, including investigational drugs and hazardous drugs.

4.9 P&T Committee shall review adverse drug reactions in the hospital and recommend policies regarding the reporting of such reactions.

- 4.10 P&T Committee shall review drug utilization patterns and recommend policies for rational drug therapy in the hospital.
- 4.11 P&T Committee shall approve pharmacy educational programs for the hospital professional staff on matters related to drug use.

5. Meeting Schedule

- 5.1 The P&T Committee shall meet at least once every two months, or as determined by the Committee Chairperson.

HOSPITAL ETHICS COMMITTEE (HEC)

1. Committee Mandate

- 1.1 The Hospital Ethics Committee (HEC) will have the overall responsibility to facilitate the establishment of a community of health care professionals at the Hospital who are sensitive to issues of ethics in health care.

2. Membership

- 2.1 Chair • Head Internal Medicine
- 2.2 Members - Representatives from:
- Medical Oncology
 - Surgery
 - Paediatrics
 - Anaesthesia
 - Nursing
 - Psychiatry
 - Law Officer
 - Manager Quality Assurance
- 2.3 The Chair will serve for three years, while membership tenure will be for two years.
- 2.4 Law Officer will act as Secretary to the Committee.

3. Reporting Relationship

- 3.1 The committee shall report to the Medical Director and Clinical Executive Board (CEB). Details of Ethics-consult will be confidential and only a summary report will be presented.

4. Activities

4.1 The role of the committee will be advisory

4.2 The committee will provide two specific services: Ethics Consultative Service and Education.

4.2.1 Ethics Consultative Service

4.2.1.1 Ethics consultative service will facilitate the resolution of ethical dilemmas that arise in the management of patients at the Hospital. The service will ensure that the decisions are based on:

- Ethical principles and not on personal attitude or intuition.
- On moral and ethically defensible grounds and not on prejudice, or the authority of one individual and always in the best interest of the patient.

4.2.1.2 A consult is required when there is a conflict of moral/ethical values between two parties, i.e., two health professionals, patient and physician, and patient and family during the patient care process.

4.2.1.3 An ethics consult can be triggered by anybody including the patient, family, physician or staff.

4.2.1.4 A member of the Hospital Ethics Committee will be on call 24 hours a day. He/she will carry a pager. The pager number will be advertised and communicated to all hospital faculty and staff.

4.2.1.5 The information brochure handed to patients on admission will include information about the Ethics Consult Service and how to access it.

4.2.2 Education

4.2.2.1 Development and presentation of educational programmes on ethical issues

4.2.2.2 Continuing self-education of the committee members

4.2.2.3 Awareness and education of the patient, health professionals and other staff at the hospital

4.3 The committee will maintain confidentiality on the issues discussed.

4.4 Future scope

4.4.1 After the initial development of awareness amongst the hospital staff viz., scope of

the committee can be enlarged to:

- Review of institutional policies that have ethical implications in patient care processes
- New services such as organ donation

5. Meeting Schedule

- 5.1 The HEC shall meet at least once every four months, or as determined by the Committee Chairperson.

OPERATING ROOM COMMITTEE (O.R. COMMITTEE)

1. Committee Mandate

- 1.1 The OR Committee will have overall responsibility to develop OR capacity to meet existing and anticipated demands from all surgical services. Both elective and emergency demands should be considered in determining space, equipment and staff requirements.

2. Membership

- 2.1 Chair Representative from: • Surgical Oncology

- 2.2 Members - Representatives from:
- Anaesthesia
 - Surgery
 - Emergency Medicine
Manager CSSD
 - Manager OR
 - Manager Quality Assurance

- 2.3 The Chair will serve for three years, while membership tenure will be for two years.

- 2.4 Manager OR will act as Secretary to the Committee.

3. Reporting Relationship

- 3.1 The committee shall report to the Medical Director and Clinical Executive Board (CEB), as well as the Hospital Director.

4. Activities

- 4.1 The committee will review all surgical services utilization information. Reallocation of block time will occur on a quarterly basis.
- 4.2 The committee will ensure high quality and cost effectiveness in patient care, safety, OR

personnel and efficient utilization of OR resources by:

- 4.3.1 Establishing and monitoring quality standards, job descriptions, and credentials applicable in OR service areas.
- 4.3.2 Recommending solutions to recurring and important problems brought to the committee's attention by members, OR user's or the Clinical Executive Board (CEB). The problem may be in the forms of an incident report, patient complaint or as a result of tracking quality and efficiency indicators.

5. Meeting Schedule

- 5.1 The ORC shall meet at least once every three months, or as determined by the Committee Chairperson.

RADIATION PROTECTION COMMITTEE (RPC)

1. Committee Mandate

- 1.1 The committee ensures the protection of staff, patients and members of public against the hazards of ionizing radiation, while using ionizing radiation for professional needs, at the Institution thereby creating a radiation safe work environment.

2. Membership

- 2.1 Chair Representative from: • Nuclear Medicine
- 2.2 Members - Representatives from:
 - Radiology – two members
 - Radiation Oncology – two members
 - Nursing
 - Medical Physicist
 - Manager Radiology
 - Manager Quality Assurance

- 2.3 The Chair will serve for three years, while membership tenure will be for two years.

- 2.4 Medical Physicist will act as Secretary to the Committee.

3. Reporting Relationship

- 3.1 The committee shall report to the Medical Director and Clinical Executive Board (CEB).

4. Activities

- 4.1 Personnel Radiation Dose Monitoring:
 - 4.1.1 Categorize and authorize active users of ionized radiation at the Institution and monitor their radiation doses
- 4.2 Nuclear Licensing of the Institution
 - 4.2.1 The R. P. C manages the licensing of the Institution for the use of nuclear material. It is also responsible for procurement of the same.
- 4.3 Use of Radiation and Radioactive Waste Disposal:
 - 4.3.1 Various departments use nuclear material in different forms for research and Clinical purposes. The Radiation Protection Committee looks after the disposal of radioactive waste generated. Proper waste disposal is important for a radiation safe environment. In addition, the identification of radioactive/hot areas using radiation hazard signs is another important aspect of Radiation Protection. Furthermore, clearly defining various procedures for managing radiation accidents/incidents is an important aspect of radiation protection and guidance in this regard is provided by R.P.C.
- 4.4 External Links:
 - 4.4.1 Establish liaison with the Pakistan Atomic Energy Commission and other Organizations on various matters, such as Radiation Protection rules and regulations for hospitals and facilitate the implementation of their recommendations. Arrange time to time survey of the Institution by the Atomic Energy inspectors.
- 4.5 Radiation Education:
 - 4.5.1 Develop and implement radiation protection courses for various staff and Students.
- 4.6 Development of Radiation Protection guidelines for the Hospital
- 4.7 Radiation protection issues while implementing new services involving radiation or when research work is carried out using radioactivity.
- 4.8 Ethical issues associated with radiation related research such as radiation risks to personnel and volunteers, if any.
- 4.9 Any other radiation related issue that may arise in future as the hospital implements newer uses of radiation.

5. Meeting Schedule

- 5.1 The RPC shall meet at least once every four months, or as determined by the Committee Chairperson.

NUTRITION SUPPORT COMMITTEE (NSC)

1. Committee Mandate

- 1.1 Committee should develop and approve the policies regarding nutritional screening and develop methods/ tools of assessment for inpatients.
- 1.2 Committee should prepare, review and approve nutritional education program for patients, their families, medical and paramedical staff and prepare nutrition education material appropriate for use by patient and their families.

2. Membership

- 2.1 Chair Representative from: • Gastroenterology
- 2.2 Members - Representatives from:
 - Medicine
 - Surgery
 - Nursing
 - Clinical Nutritionist
 - Environmental & Hotel Services
 - Manager Quality Assurance
- 2.3 The Chair will serve for three years, while membership tenure will be for two years.
- 2.4 Clinical Nutritionist will act as Secretary to the Committee.

3. Reporting Relationship

- 3.1 The committee shall report to the Medical Director and Clinical Executive Board (CEB).

4. Activities

- 4.1 The role of the committee shall remain advisory on nutrition-related matters and issues.
- 4.2 The committee shall prepare nutrition education material on various aspects
- 4.3 The committee shall develop nutritional screening criteria for all patients. Additionally, NSC shall also develop policies & procedures related to Diet and nutrition.

5. Meeting Schedule

- 5.1 The NSC shall meet at least once every two months, or as determined by the Committee Chairperson.

INTENSIVE CARE UNITS COMMITTEE (ICUC)

1. Committee Mandate

1.1 The ICUC shall be responsible for the over all monitoring and evaluation of quality assurance activities related to Medical and Surgical Intensive and Coronary Care facilities (hereinafter referred to as Intensive care units or ICUs).

1.2 The committee shall identify and rectify long-standing problems related to ICUs.

2. Membership

2.1 Chair Representative from: • Internal Medicine

2.2 Members - Representatives from:

- Cardiology
- Surgery
- Paediatrics
- Anaesthesia
- Obstetrics & Gynaecology
- Emergency Medicine
- Pathology
- Blood Bank
- Nursing (Incharge ICU)
- Manager Quality Assurance

2.3 The Chair will serve for three years, while membership tenure will be for two years.

2.4 Nurse Incharge ICU will act as Secretary to the Committee.

3. Reporting Relationship

3.1 The committee shall report about its activities to the Medical Director and Clinical Executive Board (CEB) as well as the Hospital Director

4. Activities

4.1 The ICUC shall be responsible for the professional practice of critical care medicine at the Institutional Hospital

4.2 ICUC shall develop and implement policies and procedures pertaining to the utilization of Intensive Care Unit facilities.

- 4.3 It shall serve as a recommending body to hospital administration for acquiring additional resources and modifying existing resources for the various ICUs as the need arises.
- 4.4 ICUC shall implement measures to monitor issues related to the quality of care being delivered in the Intensive Care Units as part of the Quality Assurance Program of the institution
- 4.5 It shall act as a forum where issues relating to critically ill patients in various departments may be discussed and resolved

5. Meeting Schedule

- 5.1 The ICUC shall meet at least once every two months, or as determined by the Committee Chairperson.

MEDICAL RECORDS COMMITTEE (MRC)

1. Committee Mandate

- 1.1 The Medical Records Committee (MRC) will have overall responsibility for assuring quality documentation and compliance with documentation requirements as approved by the Quality Control Committee (QCC).

2. Membership

- 2.1 Chair Representative from: • Medicine
- 2.2 Members Representatives from:
 - Psychiatry
 - Surgery
 - Paediatrics
 - Obstetrics and Gynaecology
 - Pathology
 - Clinical Research
 - Nursing
 - Manager Medical Records
 - MIS representative
 - Manager Quality Assurance
- 2.3 The Chair will serve for three years, while membership tenure will be for two years.

- 2.4 Manager Medical Records will act as Secretary to the Committee.

3. Reporting Relationship

- 3.1 The committee shall report to the Medical Director and Clinical Executive Board (CEB) as well as the Hospital Director.

4. Activities

- 4.1 The MRC will be responsible for the following functions:
- 4.1.1 At least quarterly review of medical records for timely completion and consistency of clinical documentation. The result and recommendations of the audit will be forwarded to QC for action and follow-up.
- 4.1.2 Determination of the format of the complete medical record, the forms used in the record, and the use of electronic data processing and storage system for medical record purposes.
- 4.1.3 Advise the administration in matters pertaining to medical records.
- 4.1.4 Submit monthly minutes to the QCC, listing activities, and identified problems with recommendations, proposed solutions and alternative options.
- 4.1.5 Recommend various policies with respect to medical records as and when required.

5. Meeting Schedule

- 5.1 The MRC shall meet at least once every four months, or as determined by the Committee Chairperson.

INFECTION CONTROL COMMITTEE (ICC)

1. Committee Mandate

- 1.1 Infection Control Committee is a policy making body charged with:
- 1.1.1 Guiding the infection control team (ICT) in carrying out its activities.
- 1.1.2 Creating and maintaining an environment which minimizes the risk of infection to all patients, care givers and visitors by Policy making, consultation, education, immunization / vaccination, surveillance and research activities.
- 1.1.3 Reviewing, revising and approving the Infection Control Manual every 3 years or whenever the need arise.
- 1.1.4 Enhancing the image of Infection Control in the organization, community and country at large.

2. Membership

- 2.1 Chair Representative from: • Infectious Disease Division
- 2.2 Membership Representatives from:
- Medical Oncology
 - Infectious Diseases
 - Surgery
 - Pathology
 - Paediatrics
 - Obstetrics and Gynecology
 - Infection Control Nurse
 - Manager CSSD
 - Environmental & Hotel Services
 - Manager Quality Assurance
 - Microbiology Supervisor
- 2.3 The Chair will serve for three years, while membership tenure will be for two years.
- 2.4 IC Nurse will act as Secretary to the Committee.

3. Reporting Relationship

- 3.1 The committee shall report to the Medical Director, Clinical Executive Board (CEB) and Hospital Director.

4. Activities

- 4.1 Hold regular committee meetings and submit meeting minutes to Clinical Executive Board (CEB).
- 4.2 Submit quarterly Infection Control Report to Clinical Executive Board (CEB).
- 4.3 Guide infection control team in carrying out the following activities:
- 4.3.1 Surveillance of Nosocomial Infections as defined by:
- Nosocomial blood stream infection
 - Nosocomial pneumonia
 - Nosocomial Urinary Tract Infections
 - Surgical wound infections
 - Multiple Antibiotics Resistant Organisms
- 4.3.2 Notifiable Infectious Disease care monitoring
- 4.3.3 Needle Stick Injury management and exposure to HBV, HCV and HIV contaminated blood/body fluids

- 4.3.4 Universal precautions, safety measures, and environmental control audits in all patient care and relevant areas e.g. Pharmacy, Laboratory etc
- 4.3.5 Monitoring of decentralized infection control activities in support service departments by getting reports on quality indicator in the form of quarterly presentations, in infection control meeting, by the departments
- 4.3.6 Monitoring of decentralized infection control activities by providing consultation and recommendations when required by the departments such as Food Services, CSSD, Maintenance, Employee Health, and Housekeeping etc
- 4.3.7 Actively participate in employee orientation and education program.
- 4.3.8 Developing, implementing and reinforcing Infection Control Procedures
- 4.3.9 Organize, conduct and support educational programs on Infection Control

5. Meeting schedule

- 5.1 The ICC shall meet at least once every two months, or as determined by the Committee Chairperson.

BLOOD BANK COMMITTEE (BBC)

1. Committee Mandate

- 1.1 The BBC shall be responsible for the over all monitoring and evaluation of quality assurance activities and programs related to blood and blood products usage in the hospital.
- 1.2 The committee shall identify and rectify long-standing and day-to-day problems related to blood and blood products usage.

2. Membership

- 2.1 Chair Representative from: • Emergency medicine
- 2.2 Members Representatives from:
 - ICU
 - Medicine
 - Surgery
 - Paediatrics
 - Anaesthesia
 - Pathology
 - Nursing

- Manager Marketing & Fundraising
- Manager Laboratory & Blood Bank
- Manager Quality Assurance

2.3 The Chair will serve for three years, while membership tenure will be for two years.

2.4 Manager Laboratory & Blood Bank will act as Secretary to the Committee.

3. Reporting Relationship

3.1 The committee shall report to the Medical Director and Clinical executive Board (CEB).

4. Activities

4.1 The committee shall arrange for regular audit in the processes of blood and blood products transfusion. Processes such as donor recruitment, donor bleeding, Blood grouping & cross matching, microbiological testing, storage, record keeping, transport of blood to the inpatient areas/O.R, transfusion, patients' well being during and post transfusion, and transfusion reactions, would be reviewed.

4.2 The BUC shall ensure the provision of quality services in terms of Blood and blood products to all the patients.

4.3 The committee shall be responsible to implement Maximum Surgical Blood order Schedule (MSBOS).

4.4 The committee shall monitor the safety aspects of the blood and blood products, including microbiological safety and serological safety. It will make arrangements to record any untoward effects of blood and blood products and take actions to prevent such occurrences.

4.5 The committee shall be responsible for teaching any aspects of blood transfusion medicine that it deems necessary (possibly after an audit) to physicians, residents/medical officers, nursing staff, technologists or porters in the form of formal lectures, tutorials, booklets and leaflets.

4.6 In the light of information gained from audit reports the committee shall suggest improvements in the services.

5. Meeting Schedule

5.1 The BUC shall meet at least once every three months, or as determined by the Committee Chairperson.

HOSPITAL SAFETY COMMITTEE (HSC)

1. Committee Mandate

- 1.1 The safety committee will take over-all responsibility for the coordination of an effective safety management program.
- 1.2 The Committee will have an advisory role to the Quality Council and user departments on safety issues.

2. Membership

- 2.1 Chair Representative from: • Orthopaedic Surgery

- 2.2 Members

- Manager OPD
- Manager Quality Assurance
- Manager EHS
- Representative E & M department
- Manager Administration & Security
- Patients Relations Officer
- Representative HR

- 2.3 The Chair will serve for three years, while membership tenure will be for two years.
- 2.4 Manager Administration & Security will act as Secretary to the Committee.

3. Reporting Relationship

- 3.1 The committee shall report to the Medical Director and Clinical Executive Board (CEB) and the Hospital Director.

4. Activities

- 4.1 The Committee will assist Quality Control Committee and user departments in preparing safety policies and procedures.
- 4.2 Participate in the orientation-training program for new employees and ongoing continued education program for onboard staff.
- 4.3 On need basis, assist QCC and user departments in preparing training material.
- 4.4 Participate in the multidisciplinary and theme inspections/audits of their area.
- 4.5 Review summary of safety and security related incidents, and design preventive measures for reductions of such occurrences.
- 4.6 Identify, and design remedial steps for unresolved workplace safety and security issues.

- 4.7 Design a Disaster Plan / Major Incident Plan.
- 4.8 Submit a quarterly report to the Quality Council, listing activities, and identified problems with recommendations, proposed solutions and alternative options.
- 4.9 Identify and recommend specialist training needs, with reference to safety, for employees.

5. Meeting Schedule

- 5.1 The Safety committee shall meet at least once every two months, or as determined by the Committee Chairperson.

CLINICAL AUDIT COMMITTEE (CAC)

1. Introduction:

Clinical audit is defined as “A quality improvement process that seeks to improve patient care against explicit criteria and implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service levels and further monitoring is used to confirm improvement in healthcare delivery”.

2. Committee Mandate

- 2.1 The clinical audit committee will ensure implementation of a yearly Organization wide Audit Plan for continuous evaluation of clinical quality.

3. Membership

- 3.1 Chair Representative from: • Surgery
- 3.2 Members Representatives from:
 - Pathology
 - Paediatrics
 - Manager Quality Assurance
 - Quality Assurance Officer

- 3.3 The Chair will serve for three years, while membership tenure will be for two years.

- 3.4 Quality Assurance Officer will act as Secretary to the Committee.

4. Reporting Relationship:

4.1 The committee shall report to the Medical Director and Clinical Executive Board (CEB).

5. Activities:

5.1 Develop & implement a systematic corporate approach to clinical audit.

5.2 CAC shall be responsible for planning and scheduling the clinical audit plan.

5.3 CAC shall be responsible for the selection & allocation of topics for audit to the relevant Consultants.

5.4 Encourage a multidisciplinary approach to clinical audit; that tracks the patient's journey delivering evidence based care.

5.5 Ensure clinical audit has a high profile and findings/best practices are shared among the medical staff.

5.6 CAC shall analyze and review the clinical audit reports.

6. Meeting Schedule

6.1 The Clinical Audit committee shall meet at least once every three months, or as determined by the Committee Chairperson.