Shaikh Zayed Federal Postgraduate Medical Institute

Federal Medical Teaching Institution

REGULATIONS

2022

Lahore

TABLE OF CONTENTS

I. SHAIKH ZAYED FEDERAL POSTGRADUATE MEDICAL INSTITUTE 1

1. Overview 1
2. Federal Postgraduate Medical Institute (FPGMI) 1
3. Shaikh Zayed Hospital (SZH) 2
4. Shaikha Fatima Institute Of Nursing & Health Sciences (SFINHS) 3
5. Shaikh Khalifa Bin Zayed Al-Nahyan Medical and Dental College (SKZMDC) 4

II. INTRODUCTION TO THE SZPGMI REGULATIONS 2022 1

III. BOARD OF GOVERNORS 3

1. Overview 3
2. Board and Committee Meetings 3
3. Human Resource Committee 4
4. Finance and Audit Committee 5

IV. MANAGEMENT COMMITTEE 6

1. Overview 6
2. Dean 7
3. Hospital Director 9
4. Medical Director 11
5. Nursing Director 14
6. Finance Director 15

V. GOVERNANCE STRUCTURE OF THE HOSPITAL 18

1. Hospital Executive Committee 18
2. Nursing Department 18
3. Medical College/ Institutes 18

4. Academic Council 19
5. Clinical Executive Committee 19
VI. GENERAL REGULATIONS FOR ALL EMPLOYEES OF THE SZPGMI 20
1. Employee Conduct 20
2. Working Hours for SZPGMI Staff 20
3. Institutional Private Practice 20
4. Civil Servants 21
VII. EMPLOYEE RECRUITMENT 22
1. Overview 22
2. Faculty Recruitment 22
3. Medical Consultants 23
4. Deputation 24
5. Recruitment Of House staff 24
6. Recruitment of Nursing Staff 24
7. Recruitment of Paramedical Staff 24
8. Recruitment of Administrative/Non-Medical Support Staff 24
VIII. EMPLOYEE PROMOTIONS 25
1. Faculty Promotion 25
2. Institutional Promotions Committee 25
3. Departmental Promotions Committee 26
4. Appointment of Heads Of Department 26
5. Non-Faculty Promotions 26
IX. EMPLOYEE GRIEVANCE PROCEDURE 27
X. DISCIPLINARY PROCEEDINGS 28
XI. BUDGETARY PROCESS 29

XII. APPENDIX 1: HOSPITAL ADMINISTRATIVE STRUCTURE **30**

XIII. APPENDIX 2: MEDICAL STRUCTURE **31**

XIV. APPENDIX 3: NURSING STRUCTURE **32**

XV. APPENDIX 4: ACADEMIC STRUCTURE **33**

XVI. APPENDIX 5: ANNUAL BUDGETARY PROCESS **34**

XVII. APPENDIX 6: EMPLOYEE HANDBOOK **35**

1. Organisational Structure 36
2. Institutional Culture, Ethics and Philosophy 39
3. Code of Conduct & Behaviour 39
4. General Policies 43
5. Employee Benefits & Facilities 47
6. Safety and Security Measures 49
7. Emergency Contact Numbers 53
8. Important Phone Numbers 54
9. Site and Floor Plans 55

XVIII. APPENDIX 7: MEDICAL STAFF BY-LAWS **56**

XIX. APPENDIX 8: FACULTY SELECTION & PROMOTION **101**

1. Selection (Recruitment) Procedures 101
2. Eligibility [Recruitment] Criteria for Selection of Senior Registrar/ Assistant Professor 102
3. Eligibility Criteria for Selection [Recruitment] of Associate Professor/ Professor 105
4. Promotion Procedures 107

XX. APPENDIX 9: DISCIPLINARY POLICY **111**

1. Introduction 111
2. Grounds for Penalty 111
3. Definition of Misconduct 111

4. Penalties 112
5. Minor Penalties 112
6. Major Penalties 112
7. Inquiry Procedure 113
8. Procedure to be Observed by the Inquiry Officer and Inquiry Committee 114
9. Powers of Inquiry Officer and Inquiry Committee 114
10. Appendix 9, Section 7 Not to Apply in Certain Cases 115
11. Action in Respect of the Employee required to Proceed on Leave 115
12. Procedure of Inquiry Against Officer Lent to Provincial Government etc. 115
13. Appearance of Counsel 115
14. Appeal 115

I. SHAIKH ZAYED FEDERAL POSTGRADUATE MEDICAL INSTITUTE

1. OVERVIEW

Shaikh Zayed Postgraduate Medical Institute ("SZPGMI") was commissioned on 8 September 1986. It was built by a generous grant by His Highness Ruler of Abu Dhabi and President of the UAE, Shaikh Zayed Bin Sultan Al-Nahyan, in addition to the funds and 56 acres of beautiful land provided by the Government of Pakistan. It has become a nucleus of medical excellence over the years. As of 21 September 2021, the SZPGMI has been added to Schedule 1 of the Federal Medical Teaching Institutions Act 2021.

It has four components, Federal Postgraduate Medical Institute, Shaikh Zayed Hospital (and National Institute of Kidney Diseases - Workers Welfare Foundation Block), Shaikh Fatima Institute of Nursing and Health Sciences and Shaikh Khalifa Bin Zayed Al-Nahyan Medical and Dental College. These four components working together as one unit have provided impressive opportunity for research, training of medical and paramedical personnel and above all high standards of patient care.

2. FEDERAL POSTGRADUATE MEDICAL INSTITUTE (FPGMI)

Federal Postgraduate Medical Institute and Shaikh Zayed Hospital, Lahore were established in 1986 with the objectives of developing training facilities for postgraduate medical qualifications; educating and training medical personnel to become leaders in medical research, education and health delivery systems; developing a system to impart continuing medical health education and training.

At present it consists of the following departments:

Basic Sciences	**Clinical Sciences**	
Anatomy	General Surgery	General Medicine
Physiology	Plastic Surgery	Rheumatology
Biochemistry	Paediatric Surgery	Gastroenterology
Microbiology	Cardiothoracic Surgery	Pulmonology
Haematology	Neurosurgery	Neurology
Histopathology	Urology	Dermatology

Chemical Pathology	Kidney Transplant Surgery	Nephrology
Pharmacology	Hepato-Billiary & Liver Transplant Surgery	Cardiology
Forensic Medicine	Obstetrics and Gynaecology	Psychiatry
Public Health & Community Medicine	Otolaryngology	Paediatrics
	Orthopaedics	Neonatology
	Anaesthesia and Critical Care Medicine	Radiology

It runs postgraduate training programs in all specialties. Current strength of Postgraduate Residents enrolled in the Institute (in PhD/FCPS/MS/MD/M.Phil/MCPS/Diploma courses) is 521.

It conducts regular Continuing Medical Education (CME) activities which include Clinicopathological Conferences, Symposia, Seminars, Workshops, Intensive Review Courses etc. A Scientific Journal Proceedings in published quarterly, which is also recognized by Pakistan Medical Commission (PMC) and Higher Education Commission (HEC), Islamabad.

3. SHAIKH ZAYED HOSPITAL (SZH)

Shaikh Zayed Hospital (SZH) was established in 1986 as a 350 bed hospital, and has since grown into a 1,031 bed tertiary care hospital with:

(1) General Wards

(2) Al-Nahyan Wards (Private Rooms)

(3) ICU (Intensive Care Unit)

(4) CCU (Coronary Care Unit)

(5) 54 Machine Dialysis Unit

(6) Well Equipped Operation Theatres

(7) Well Equipped Labs

It provides outpatient and inpatient clinical services in:

General Surgery	Cardiothoracic Surgery	Cardiology
Urology	Paediatric Surgery	Dermatology
Kidney Transplant	Neurosurgery	Nephrology
Hepato-Billiary & Liver Transplant	Anaesthesia and Critical Care	Psychiatry
Obstetrics and Gynaecology	General Medicine	Paediatrics
Otolaryngology	Rheumatology	Neonatology
Ophthalmology	Gastroenterology	Radiology
Orthopaedics	Pulmonology	Pathology
Plastic Surgery	Neurology	

4. SHAIKHA FATIMA INSTITUTE OF NURSING & HEALTH SCIENCES (SFINHS)

Shaikha Fatima Institute of Nursing and Health Sciences ("SFINHS") was established in 1994 as a component of SZPGMI to meet the increasing demand of nurses, medical technologist (undergraduate & postgraduate) and other paramedics from all over the country. Since the inception of the SFINHS, it has been fulfilling all its objectives and the performance of our students has been outstanding. Our students scored the top position in the Nursing Examination Board, whereas students of B.Sc. Medical Lab. Technology remain in the top positions of University Examinations.

The SFINHS is well equipped with excellent facilities including eight classrooms furnished with multimedia, audio visual equipment, white boards and air-conditioners. There are four laboratories catering to the practical requirements of B.Sc. MLT, B.Sc. Nursing and Paramedical students. The students rotate through the functional laboratories of Shaikh Zayed Hospital where they get hands on training in laboratory medicine. The hospital labs contain the latest equipment required to carry out most of the tests required for patients. A library facility and a well furnished computer lab with high speed internet connectivity are available to the students of SFINHS. Sports facilities include a large green ground and tennis court. A sports coach is available on the premises and regular sports and extracurricular activities are organized during the academic year.

The nursing student hostel comprises 52 fully furnished rooms across two floors, and includes a hygienic kitchen, TV lounge, visiting room and prayer room. The hostel building overlooks a delightful fountain, which adds to the pleasant environment for the hostel residents.

The SFINHS continues to strive for excellence both in professional training and planning competence. With an aim to prepare highly skilled nurses that excel in every field within our country and abroad, the SFINHS is offering the following programs:

	Program	Duration
(a)	B.Sc. Medical Laboratory Technology (Hons)	04 years
(b)	B.Sc. Nursing (Hons)	04 years
(c)	General Nursing Course including Midwifery (phasing out from 2018)	04 years
(d)	Post RN degree program (since 2018)	02 years

(e) Paramedical courses as under:

Dispenser	Ophthalmic Technician
Medical Laboratory Technology	Anaesthesia Technician
Radiography & Imaging Technology	Assistant Cardiac Perfusionist
Operation Theatre Technology	ECG Technician
Haemodialysis Technician	EEG Technician
Dental Technician	Orthopaedic Technician
Physiotherapy Technology	Endoscopy Technician

There are plans to introduce new Diploma, M.Sc. and M.Phil courses over time.

5. SHAIKH KHALIFA BIN ZAYED AL-NAHYAN MEDICAL AND DENTAL COLLEGE (SKZMDC)

Shaikh Khalifa Bin Zayed Al-Nahyan Medical and Dental College ("SKZMDC") is one of the components of the SZPGMI. It was inaugurated by the Honourable Prime Minister of Pakistan Mr. Sayed Yousaf Raza Gilani on 23 May 2009 in the premises of SZPGMI. The aim to establish an undergraduate college was to inspire, educate and produce enthusiastic young medical professionals by employing problem based learning and modern information technology.

SKZMDC is attached with the Shaikh Zayed Hospital. The college has Pakistan Medical Commission approved need based curriculum for undergraduate medical students to further strengthen the basic foundation of medical education in Pakistan. It is affiliated with the University of Health Sciences, Lahore and recognized by the PMC, Islamabad. The official college magazine *Phoenix* is published annually. The undergraduate medical college also publishes its own newsletter.

The college has gained popularity due to continued exceptional results in Professional Examinations. The college was fourth on the merit list of UHS admission throughout the Punjab Province, from 2015 till 2020, which is a great achievement and demonstrates a high standard of education.

II. INTRODUCTION TO THE SZPGMI REGULATIONS 2022

In exercise of the powers conferred upon it through Section 26 (1) of Federal Medical Teaching Institutes Act (herein referred as “FMTI Act” or “the Act”) 2021 and widely publicize it for a period of 15 days as required under Section 26(2) of the *said* FMTI Act.

Short title, application and commencement.

(1) These Regulations will be called the Shaikh Zayed Federal Postgraduate Medical Institute Regulations, 2022 (amended time to time), or referred to as “the Regulations” hereunder;

(2) The Regulations shall apply to the SZPGMI, a Federally owned or operated Medical Teaching Institute and its Components, as listed hereunder and collectively referred to as the SZPGMI or “the Institute”:

(a) Federal Postgraduate Medical Institute, Lahore (“FPGMI” or “Postgraduate Medical College/Institute”)

(b) Shaikh Zayed Hospital (“SZH” or “the Hospital”)

(c) Shaikha Fatima Institute of Nursing and Health Sciences (“SFINHS” or “Nursing and Allied Health Sciences College/Institute”)

(d) Shaikh Khalifa Bin Zayed Al-Nayhan Medical and Dental College (“SKZMDC” or “Undergraduate Medical College/Institute”)

(3) They shall come into force at once.

(4) **Definitions.—**In these Regulations, unless the context otherwise requires,—

(a) "Basic Science Faculty" includes a medical faculty not involved in patient care;

(b) "Board" or “BOG” means the Board of Governors constituted under Section 4 of the FMTI Act;

(c) "Chairperson" means the Chairperson of the Board;

(d) "Clinical Faculty" includes a medical faculty involved in any manner with a clinical care of patients, whether diagnostic or therapeutic;

(e) “College” means a Medical, Dental, Nursing or a Paramedical College in the public sector under SZPGMI;

(f) “Consultant” means and includes—

(i) Those medical faculties involved in patient care; or

(ii) Those staff who act as service provider to the patients in the hospital

(g) “Dean” means the academic head of the SZPGMI;

(h) “Employee” means a person who is—

  (i) An employee appointed by the Board of the SZPGMI under these regulations made there-under; or

  (ii) A civil servant who has opted to become an employee of the SZPGMI under Section 17 of the FMTI Act.

(i) “Federal Medical Teaching Institution” means a public sector medical, dental or nursing college or any other medical teaching institution and their affiliated teaching hospitals located anywhere in Pakistan owned and controlled by the Federal Government and included or notified by the Federal Government in Schedule-I to the FMTI Act, 2021;

(j) “FMTI Act” means the Federal Medical Teaching Institutions FMTI Act, 2021

(k) “Medical Faculty” means and includes the basic science faculty and clinical faculty which includes Senior Registrar and above as well as Dean of the SZPGMI, involved in teaching, training or patient care;

(l) “Government” means the Federal Government;

(m) “Healthcare Services” means preventive, curative, promotive, rehabilitative health services and include diagnostic, support services, laboratory, accident and emergency, pharmacy and paramedic support;

(n) “Management Committee” means a committee notified as per Section 9(1) of the Act;

(o) “Member” means a member of the Board of Governors and includes the Chairperson;

(p) "Prescribed" means prescribed by rules or regulations made under the FMTI Act; •

(q) "Regulations" means regulations made under the FMTI Act;

(r) "Rules" means rules made under the FMTI Act;

(s) "Search and Nomination Council" means search and nomination council notified by the Government under Section 7 of the FMTI Act, and

(t) "Tribunal" means the Federal Medical Teaching Institutions Tribunal established under this FMTI Act.

(u) “HR Committee” means the Human Resource Committee notified by the Board and headed by a Board member as its Chair.

(v) “Finance and Audit Committee” means the Finance and Audit Committee notified by the Board and headed by a Board member as its Chair.

(w) “Sub-Committee” means a committee notified by the Board or the Management Committee for any specific purpose for input / assistance / advice to the Board or the Management Committee.

III. BOARD OF GOVERNORS

1. OVERVIEW

(1) The Board will have overall authority and responsibility for the SZPGMI and will report to the Government as prescribed.

(2) The Board will be responsible for implementing the basic standards as laid down under the FMTI Act 2021.

(3) The Board will ensure adherence to the minimum qualification standards for all posts in the SZPGMI laid down by the Board to ensure merit based appointments, provided that the Board may enhance such minimum qualification of merit at their discretion.

(4) The Board shall in prescribed manner appoint the Dean, Hospital Director, Medical Director, Nursing Director and Finance Director of SZPGMI.

(5) For all other appointments in SZPGMI, apart from those of the Management Committee, the Board may delegate to the Dean, Medical Director, Hospital Director and the Nursing Director, the process of recruitment of all personnel under their respective authorities, except that the Rules and Regulations will be followed in these selections and the principles of transparency, fairness and equity will be followed. The selection criteria and appointment process will be prepared and approved by the Management Committee.

(6) Final approval of appointments of all non-medical faculty SZPGMI employees rests with the Management Committee. However, the Board has the right to review any appointment(s) as and when they may deem fit.

(7) Final approval of all medical faculty positions rests with the Dean. However, the Board has the right to review any appointment(s) as and when they may deem fit.

(8) the Board may review selected appointments of all SZPGMI employees if they deem fit with the powers to cancel any appointment even after appointment is actualized in case an unfit candidate is selected for any slot. The Board will be kept informed of all appointments made by the Dean and/or Management Committee.

2. BOARD AND COMMITTEE MEETINGS

(1) The Board will meet at least every three (3) months and more frequently if the Board deems necessary to carry out its responsibilities and duties;

(2) The date and venue of the Board meeting will be intimated to the members at least seven (7) days before the meeting;

(3) All members attending Board or Management Committee meetings must sign in to document their attendance.

(4) Written minutes will be kept of each Board and Committee meeting by the Chair or his designee with complete record maintenance by the Secretary of the Board.

(5) Each Board meeting will continue until all essential agenda items have been satisfactorily resolved;

(6) Board meetings will be attended by the Dean, Hospital Director, Medical Director, and the Nursing Director, as invited guests to make presentations to the Board as required. These attendees may leave the Board meeting after their individual presentations unless otherwise required by the Board;

(7) The Finance Director will make a presentation of the Annual Financial Report to the Board once a year, and will also attend the budget meetings of the Board; the Finance Director may also be required to attend other meetings as deemed necessary by the Board;

(8) An excused absence, by and invited guest, from the Board meeting will require prior approval of the Board, with a written explanation sent to the Board at least three (3) days prior to the meeting;

(9) Employees of the SZPGMI may address the Board, after having given prior notice to do so at least one (1) week before any Board meeting, through proper channel. Employees may address the Board for a maximum of ten (10) minutes and no discussion will be permitted, except at the discretion of the Board;

(10) Employees may request a meeting with the Board, through proper channel, at a separate time from the Board meeting; the Board may approve or disapprove the request;

(11) The Board will complete review of the annual Institutional budget and forward the same to the government by March 31st of each year;

(12) The Board may constitute Committees of the Board, and such other committees or sub-committees as it may deem appropriate. The Board will name the chair and membership of such committees as mentioned under Section 5(7) of the FMTI Act;

(13) The Board shall approve the terms of reference and functions of each Board committee;

(14) The Board committees shall suggest, recommend and assist the Board in making decisions;

(15) Each committee, at its first meeting, shall confirm membership and appoint a Secretary who shall take minutes and keep a record of each meeting;

(16) The chair of the committee shall call meetings of the committee as required in the specific terms of reference of that committee. The committee may also meet at the request of the Board;

(17) The minutes of each committee meeting shall be forwarded to the Board;

3. HUMAN RESOURCE COMMITTEE

(1) The Board shall constitute a Human Resource Committee ("HR Committee") which shall suggest, recommend and assist the Board in all matters relating to human resource;

(2) The HR Committee shall elect a Chair of the committee from the members of the committee nominated by the Board;

(3) The terms of reference of the Human Resource Committee would be notified in due course

4. FINANCE AND AUDIT COMMITTEE

(1) The Board shall constitute a Finance and Audit Committee, which shall suggest, recommend and assist the Board in all matters relating to finance;

(2) The Finance and Audit Committee shall elect a Chair of the committee from the members of the committee nominated by the Board;

(3) The terms of reference of the Finance and Audit Committee would be notified in due course

IV. MANAGEMENT COMMITTEE

1. OVERVIEW

(1) For the SZPGMI there shall be a Management Committee for the overall coordination of the Institution. The Management Committee shall consist of:

(a) Dean SZPGMI; Chair

(b) Hospital Director; Member

(c) Medical Director; Member ,

(d) Nursing Director; Member

(e) Finance Director; Member

(f) Any other two persons appointed by the Board on the recommendation of the Dean SZPGMI; Members

(2) The secretary to the Dean will act as secretary to the Management Committee;

(3) The Management Committee will report to the Board;

(4) The Management Committee will meet every month or more frequently if the Management Committee or the Board deem necessary;

(5) The quorum necessary for Management Committee meetings shall be five (5) members;

(6) The Management Committee will review the overall performance of the Institution and implement processes to streamline functions across departments, preventing duplication and ensuring the most efficient and cost effective function;

(7) The Management Committee shall review and recommend to the Board the annual budget for SZPGMI in the prescribed manner;

(8) The Management Committee will have full authority to approve all payments above Rupees fifty million (PKR 50,000,000), so long as they are within the approved budget for the SZPGMI and ensuring that all Institutional rules and procedures have been documented and followed in a transparent and fair manner, subject to strict compliance with PPRA Rules;

(9) The Dean SZPGMI will have full authority to grant approval and sanction of all pay and allowances, stipends and any other fringe benefits to the employee(s) and for payments equal to or less than Rupees Fifty million (PKR 50,000,000) at one time, including; purchase of goods, commodities, machinery & equipment, all type of services, civil/electrical/mechanical works, so long as they are within the approved budget for the SZPGMI and ensuring that all institutional rules and procedures have been documented and followed in a transparent and fair manner, subject to strict compliance with PPRA Rules;

(10) Payments equal to or less than Rupees five hundred thousand (PKR 500,000) at one time may be approved respectively by the Hospital Director for Shaikh Zayed Hospital expenditures, and by the Deputy Deans for FPGMI, SKZMDC and SFINHS expenditures, so long as they are within the approved budget for the SZPGMI, and ensuring that all Institutional rules and procedures have been documented and followed in a transparent and fair manner, subject to strict compliance with PPRA Rules;

(11) The Management Committee shall, subject to delegation of powers by the Board, appoint or terminate any or all employees of the SZPGMI in a prescribed manner or in the absence of such delegated power recommend appointment or termination of an employee to the Board;

(12) The Management Committee shall recommend to the Board any addition of a department, facility or post at the SZPGMI;

(13) The Management Committee may notify a Sub-Committee for any specific purpose for input/assistance/advice to the Management Committee;

(14) The Management Committee shall make efforts to ensure achievement of the base standards in the prescribed manner.

(15) The Management Committee shall in prescribed manner submit to the Board a quarterly report on management, health care services and financial management.

(16) The Management Committee shall perform all such other functions as may be prescribed.

2. DEAN

(1) **Term**: The Board shall appoint a Dean for the SZPGMI for a period of five (5) years, renewable for a further term of five (5) years at the discretion of the Board based upon performance and so documented by the Board. No person may serve as Dean for more than three (3) terms.

(2) No Board member shall be appointed as Dean.

(3) **Minimum Qualifications**: The Dean will be a medical academic with medical qualification such as MBBS or equivalent, plus either a PhD degree or a higher Diploma, such as a FCPS, FRCP, FRCS, FRCPath, FRCR, FRCA or a US Board certification or equivalent. The Dean will be of national and, preferably, international reputation in his/her field, which may be in the basic or clinical sciences, with at least seven (7) years administrative experience as head of a department, unit, program, or an institution, with recognized leadership qualities, a track record in teaching, and a commitment to medical education and research.

(4) **Selection Process & Criteria**:

(a) The Board may utilize the services of a reputable recruitment agency to assist with the recruitment and shortlisting process;

(b) The Board shall advertise the vacancy in at least four leading national newspapers (two English and two Urdu) specifying therein the prescribed qualifications, experience and other academic/technical requirements etc. It may also advertise in international journals/media if it so desires;

(c) For recruitment of the Dean, the Board will constitute a Selection Committee, consisting of appropriately qualified individuals as under:

(i) A full time Professor of reputable Medical Institutions/ Dean or Head of any Institution/ Teaching Hospital;

(ii) A full time Professor from SZPGMI;

(iii) A non-clinical representative from a reputable Medical Institution/ Teaching Hospital;

(iv) A senior representative of the Nursing profession; and

(v) A reputable lay person who may be a retired senior civil servant or a senior retired armed services officer or a recognized philanthropist or reputable member of civil society

(vi) The Board may co-opt two (2) further members if it feels that further expertise in necessary

(vii) The Board will designate a Chair of the Selection Committee from the members of the said committee.

(d) Relevant Human Resources Department shall score all the applicants according to the selection criteria approved by the Board and will forward the scores to the Selection Committee;

(e) The Selection Committee will call for interview top five (5) or more candidates on the basis of their quantified score based on marking criteria;

(f) The Selection Committee shall forward three (3) to five (5) candidates to the Board from the interviewed candidates;

(g) Any member of the Selection Committee who has a conflict of interest in any form, either with a specific candidate or the position, or for any other reason, will withdraw himself/herself from the process and inform the Board accordingly;

(h) The final selection authority for all posts rests with the Board;

(i) The Board will select a Dean and appoint entirely on merit, in a fair and transparent manner after fulfilling the prescribed procedure;

(j) The Board will interview the candidates;

(k) The Board may co-opt any relevant person/persons for assistance in the interview;

(l) The Board may approve or disapprove the selection of candidates as per recommendation of the Selection Committee;

(m) The Board may review the selection process and call for reinitiating the entire recruitment process or any part thereof.

(5) **Appointment**: Simultaneously with his/her appointment as Dean, the selectee will also receive a faculty appointment at the appropriate level (associate professor or full professor) in a department

appropriate to his/her specialty, which appointment shall not be limited to the term applicable to the office of the Dean.

(6) **Functions and Duties of the Dean**:

(a) *Dean as Chief Executive Officer*: Notwithstanding anything contrary to provisions of the FMTI Act, the Dean as Chief Executive Officer of SZPGMI will be known as Chairman/Chairperson and Dean and will act as the deciding authority on matters referred by the respective, Hospital Director, Medical Director, Nursing Director, Finance Director or component heads. The Dean will also ensure resolution of any disputes amongst the directors or component heads;

(b) The Dean will act in all clinical matters as Chairperson of the Management Committee as mentioned in the FMTI Act (9) (1) (a), and work closely with the Hospital Director and Medical Director;

(c) The Dean will be head/dean of FPGMI, SFINHS and SKZMDC and will be responsible for all undergraduate and postgraduate medical teaching and research, and will report to the Board and function as mentioned in Section 9 (a), and Section 10 (2) to Section 10 (6) of the FMTI Act;

(d) The Dean will be responsible for all budgetary and financial matters relating to the FPGMI and its functions;

(e) The Dean will select from the faculty a Deputy Dean (SKZMDC) for undergraduate education, a Deputy Dean (FPGMI) for postgraduate education, and a Deputy Dean (SFINHS) for Nursing and Allied Health Sciences, to be approved by the Board and designated as such, provided that nobody may simultaneously hold the positions of Dean and Deputy Dean; and Dean and Head of an academic department;

(f) The Deputy Deans will represent the Institute at relevant administrative and educational fora.

(7) **Evaluation**: The Board shall monitor the performance of the Dean through objectively verifiable indicators itself or through a disinterested party on a periodic basis. Such reports shall be the basis for continuation, termination or renewal of contract of Dean.

3. HOSPITAL DIRECTOR

(1) The Board will appoint a Hospital Director as described in Section 11 (1) of the FMTI Act;

(2) The qualifications and experience for the post of Hospital Director shall be as mentioned in Section 11(2) of the FMTI Act.

(3) **Term**: The Hospital Director shall be selected and appointed by the Board for a term of five (5) years, and shall be eligible for reappointment at the discretion of the Board based upon performance and so documented by the Board**.** No person may serve as Hospital Director for more than three (3) terms.

(4) No Board member shall be appointed as Hospital Director.

(5) **Minimum Qualifications**: The Hospital Director will have a Masters degree in Hospital Management, Health Services Management, Business Management, Public Health, Public Administration or any equivalent management qualification from a recognized institution. A minimum experience at related management level positions of seven (7) years, except that the Board may relax this condition in the case of an outstanding candidate, provided that the Board specifically documents the reasoning for the exception. A medical qualification such as MBBS or equivalent will be an advantage.

(6) **Selection Process & Criteria**:

(a) The method of appointment will be as described in Section 11(1) of the FMTI Act.

(b) The Board may utilize the services of a reputable recruitment agency to assist with the recruitment and shortlisting process;

(c) The Board shall advertise the vacancy in at least four leading national newspapers (two English and two Urdu) specifying therein the prescribed qualifications, experience and other academic/technical requirements, etc. It may also advertise in international journals/media if it so desires.

(d) The Board will constitute a Selection Committee, consisting of appropriately qualified individuals as under;

(i) A full time Professor of reputable Medical Institutions/ Dean or Head of any Institution/ Teaching Hospital;

(ii) A Full time Professor from SZPGMI;

(iii) A senior representative from the Nursing profession;

(iv) The head of a non-medical department from the Hospital; and

(v) A reputable lay person who may be a retired senior civil servant or senior retired armed services officer or a recognized philanthropist or reputable member of civil society;

(vi) The Board may co-opt two (2) further members if it feels that further expertise in necessary;

(vii) The Board will designate a Chair of the Selection Committee from amongst the members of the said committee.

(e) Relevant Human Resources Department shall score all the candidates according to the laid down selection criteria approved by the Board and forward the scores to the Selection Committee;

(f) The Selection Committee will invite for interview top five (5) or more candidates on the basis of their quantified score based on marking criteria;

(g) The Selection Committee shall forward three (3) to five (5) candidates to the Board from the interviewed candidates;

(h) Any member of the Selection Committee who has a conflict of interest in any form, either with a specific candidate or the position, or for any other reason, will withdraw himself/herself from the process and inform the Board accordingly;

(i) The final selection authority for all posts rests with the Board;

(j) The Board will select a Hospital Director and appoint entirely on merit, in a fair and transparent manner after fulfilling the prescribed procedure;

(k) The Board will interview the candidates;

(l) The Board may co-opt any relevant person/persons for assistance in the interview.

(m) The Board may approve or disapprove the selection of candidates as per recommendation of the Selection Committee;

(n) The Board may review the selection process and call for reinitiating the entire recruitment process or any part thereof.

(7) **Functions and Duties of the Hospital Director**: The functions, responsibilities and requirements of the Hospital Director will be as detailed in Section 12 (a) to (f) of the FMTI Act and further elaborated hereunder. In performance of his/her functions, the Hospital Director shall be responsible to the Board. The Hospital Director shall not have any conflict of interest with such a position. The Hospital Director shall be responsible for:

(a) All non-clinical and administrative functions of the Hospital;

(b) Preparation of the annual budget and business plan for presentation to the Management Committee and the Board;

(c) Maintenance of building and engineering services;

(d) Maintenance and development of all ancillary services, including but not limited to pharmacy, nursing, materials management, human resources, clerical, communications and security services;

(e) To act as the Principal Accounting Officer responsible and accountable for maintaining financial discipline and transparency; and

(f) For implementation and execution of Board and Management Committee policies and to achieve the targets set by the Board.

(8) **Evaluation**: The Board shall monitor the performance of the Hospital Director through objectively verifiable indicators itself or a disinterested party on periodic basis. Such reports shall be bases for continuation, termination or renewal of contract of the Hospital Director. The Hospital Director shall have no right to do private practice.

4. MEDICAL DIRECTOR

(1) All clinical department heads will report to the Medical Director.

(2) **Term**: The Medical Director will be selected and appointed by the Board for a period of five (5) years as mentioned in Section 13(1), 13(2) and 13(3) of the FMTI Act, and may be eligible for reappointment at the discretion of the Board based upon performance and so duly documented. No person may serve as Medical Director for more than three (3) terms. No Board member shall be appointed as Medical Director.

(3) **Minimum Qualifications**: The Medical Director will be a medical academic with a medical qualification such as MBBS or equivalent plus a higher Diploma (such as FCPS, FRCP, FRCS, FRCPath, FRCR, FRCA, or a US Board certification or equivalent. Suitable candidates will have a record of excellence in clinical care, and have at least three (3) years experience in leading a major hospital clinical unit in any clinical discipline, including medicine and its subspecialties, surgery and its subspecialties, pediatrics and its subspecialties, obstetrics/gynecology and its subspecialties, radiology and imaging services, pathology, ENT, ophthalmology, anesthesia; and any other clinical units.

(4) **Selection Process & Criteria**:

(a) The Board may utilize the services of a reputable recruitment agency to assist with the recruitment and shortlisting process;

(b) The Board shall advertise the vacancy in at least four leading national newspapers (two English and two Urdu) specifying therein the prescribed qualifications, experience and other academic/technical requirements, etc. It may also advertise in international journals/media if it so desires.

(c) The Board will constitute a Selection Committee consisting of appropriately qualified individuals as under;

(i) A medical consultant from a reputable medical institution;

(ii) A medical consultant representing the Hospital;

(iii) A senior representative from the Nursing profession;

(iv) The head of a non-medical department representing the Hospital; and

(v) A reputable lay person who may be a retired senior civil servant or senior retired armed services officer or a recognized philanthropist or reputable member of civil society;

(vi) The Board may co-opt two (2) further members if it feels that further expertise in necessary

(vii) The Board will designate a Chair of the Selection Committee from the members of the said committee.

(d) Relevant Human Resources Department shall score all the candidates according to the selection criteria approved by the Board and will forward the scores to the Selection Committee;

(e) The Selection Committee will invite for interview top five (5) or more candidates on the basis of their quantified score based on marking criteria;

(f) The Selection Committee shall forward three (3) to five (5) candidates to the Board from the interviewed candidates;

(g) Any member of the Selection Committee who has a conflict of interest in any form, either with a specific candidate or the position, or for any other reason, will withdraw himself/herself from the process and inform the Board accordingly;

(h) The final selection authority for all posts rests with the Board;

(i) The Board will select a Medical Director and appoint entirely on merit, in a fair and transparent manner after fulfilling the prescribed procedure;

(j) The Board will interview the candidates;

(k) The Board may co-opt any relevant person(s) for assistance in the interview.

(l) The Board may approve or disapprove the selection of candidates as per recommendation of the Selection Committee;

(m) The Board may review the selection process and call for reinitiating the entire recruitment process or any part thereof.

(5) **Appointment**: Simultaneously with his/her appointment as Medical Director, the selectee will also receive a faculty appointment at the appropriate level (associate professor or full professor) in a department appropriate to his/her specialty, which appointment shall not be limited to the term applicable to the office of the Medical Director.

(6) **Functions and Duties of the Medical Director**: The functions, responsibilities and requirements of the Medical Director will be as detailed in Section 14 (a)-(f) of the FMTI Act and further elaborated in the Regulations. The Medical Director shall be responsible for all clinical functions of the Hospital, including but not limited to:

(a) ensuring clinical excellence in all aspects of hospital functions;

(b) ensuring timely, appropriate management of patients;

(c) ensuring the best outcomes for all patients;

(d) undertaking clinical governance for quality control;

(e) assessing and auditing existing clinical programs and developing new clinical programs; and

(f) developing an annual clinical budget, including capital medical equipment requests for presentation to the Hospital Director, the Management Committee and the Board.

(7) **Evaluation**: The Board shall monitor the performance of the Medical Director through objectively verifiable indicators itself or through a disinterested party on periodic basis. Such reports shall form the basis for continuation, termination or renewal of contract of the Medical Director.

5. NURSING DIRECTOR

(1) **Term**: The Nursing Director will be appointed by the Board for a term of five (5) years which may be renewed by the Board at their discretion, for a further term, provided that no Board member shall be appointed as such. The renewal will be based upon the performance of the incumbent, and the Board will document a written explanation for such an action. No person may serve as Nursing Director for more than three (3) terms.

(2) **Minimum Qualifications**: The Nursing Director will be a qualified nurse (RN), with an advanced degree in Nursing (BScN or Post RN), preferably MScN/MA with at least seven years administrative and teaching experience in a reputable health care facility, and Current Nursing Council Registration.

(3) **Selection Process & Criteria**:

(a) The Board shall advertise the vacancy in at least four leading national newspapers (two English and two Urdu) specifying therein the prescribed qualifications, experience and other academic/technical requirements, etc; It may also advertise in international journals/media if it so desires.

(b) The Board will constitute a Selection Committee consisting of appropriately qualified individuals as under:

(i) A medical consultant from a reputable medical institution;

(ii) A medical consultant representing the Hospital;

(iii) A senior representative from the Nursing profession;

(iv) A head of a non-medical department representing the Hospital; and

(v) A reputable lay person who may be a retired senior civil servant or senior retired armed services officer or a recognized philanthropist or reputable member of civil society;

(vi) The Board may co-opt two (2) further members if it feels that further expertise in necessary

(vii) The Board will designate a Chair of the Selection Committee from the members of the said committee

(c) Relevant Human Resources Department shall score all the applicants according to the selection criteria approved by the Board and will forward the scores to the Selection Committee;

(d) The Selection Committee will invite for interview top five (5) or more candidates on the basis of their quantified score based on marking criteria;

(e) The Selection Committee shall forward three (3) to five (5) candidates to the Board from all interviewed candidates;

(f) Any member of the Selection Committee who has a conflict of interest in any form, either with a specific candidate or the position, or for any other reason, will withdraw himself/herself from the process and inform the Board accordingly;

(g) The final selection authority for all posts rests with the Board.

(h) The Board will select a Nursing Director and appoint entirely on merit, in a fair and transparent manner after fulfilling the prescribed procedure;

(i) The Board will interview the candidates;

(j) The Board may co-opt any relevant person/persons for assistance in the interview.

(k) The Board may approve or disapprove the selection of candidates as per recommendation of the Selection Committee;

(l) The Board may review the selection process and call for reinitiating the entire recruitment process or any part thereof

(4) **Functions and Duties of the Nursing Director**:

(a) The Nursing Director will report to the Board as noted in Section 15 (4) of the FMTI Act.

(b) The Nursing Director will report in the case of day to day matters to the Hospital Director and Medical Director as relevant.

(c) The Nursing Director shall be responsible for all nursing functions, including training of nurses, ensuring adequate nursing staffing for all clinical needs, maintaining the highest nursing standards and performing regular audits of nursing functions;

(d) The Nursing Director shall perform such other functions as may be prescribed by the Board.

(5) **Evaluation**: The Board shall monitor the performance of the Nursing Director through objectively verifiable indicators itself or through a disinterested party on periodic basis. Such reports shall form the basis for continuation, termination or renewal of contract of the Nursing Director.

6. FINANCE DIRECTOR

(1) **Term**: A Finance Director will be appointed for a term of 3 (three) years and shall be eligible for re-appointment at the discretion of the Board. No Board member shall be appointed as Finance Director.

(2) **Minimum Qualifications**: The Finance Director shall be a qualified chartered accountant or have ICMAP certification or have a Masters degree in Finance or Accounts. Candidates must have at least ten (10) years post qualification experience in finance and/or accounts in a major private or public company/institution registered with SECP.

(3) **Selection Process & Criteria**:

(a) The Board shall advertise the vacancy in at least four leading national newspapers (two English and two Urdu) specifying therein the prescribed qualifications, experience and other academic/technical requirements, etc; It may also advertise in international journals/media if it so desires.

(b) The Board will constitute a Selection Committee consisting of appropriately qualified indidviduals as under::

(i) One or more key officer(s) of the Institute (Dean, Hospital Director, Medical Director) if so decided by the Board;

(ii) Two (2) senior representatives from the Finance profession;

(iii) The head of a non-medical department representing the Hospital; and

(iv) A reputable lay person who may be a retired senior civil servant or senior retired armed services officer or a recognized philanthropist or reputable member of civil society

(c) The Board will designate a Chair of the Selection Committee from the members of the said committee;

(d) Relevant Human Resources Department shall score all the applicants according to the laid down selection criteria approved by the Board and will forward the scores to the Selection Committee;

(e) The Selection Committee will invite for interview top five (5) or more candidates on the basis of their quantified score based on marking criteria.;

(f) The Selection Committee shall forward three (3) to five (5) candidates to the Board from all interviewed candidates;

(g) Any member of the Selection Committee who has a conflict of interest in any form, either with a specific candidate or the position, or for any other reason, will withdraw himself/herself from the process and inform the Board accordingly;

(h) The final selection authority for all posts rests with the Board;

(i) The Board will select a Finance Director and appoint entirely on merit, in a fair and transparent manner after fulfilling the prescribed procedure;

(j) The Board will interview the candidates;

(k) The Board may co-opt any relevant person/persons for assistance in the interview.

(l) The Board may approve or disapprove the selection of candidates as per recommendation of the Selection Committee;

(m) The Board may review the selection process and call for reinitiating the entire recruitment process or any part thereof.

(4) **Functions and Duties of the Finance Director**:

(a) Coordinate and supervise all financial accounting matters of the institution,

(b) Prepare the detailed regulations and procedures for the financial management of the institution for approval by the Management Committee and the Board.

(c) Advise the Dean, Hospital Director and Medical Director on all financial matters, ensuring transparency and fiscal probity,

(d) Ensure all the accounts are kept according to rules and regulations approved by the Board

(e) Assist in the development of the Medical College/school and Hospital budgets by the Dean and the Hospital and Medical Directors, respectively, ensuring that the financial projections and financial accounts are accurate.

(f) Prepare an Annual Financial Report for approval of the Dean, Hospital Director, and Medical Director, and present the approved Annual Financial Report to the Finance and Audit Committee that will present the Annual Financial Report to the Board for formal approval.

(g) Prepare an Annual Financial Budget for next year for the approval of the Dean, Hospital Director, and Medical Director, and present the approved Annual Financial Budget to the Finance and Audit Committee.

(h) Ensure facilitation of any external audit of the accounts instituted by the Board or Government and implement the recommendations of the audit.

(i) Any differences arising on financial issues between the Dean, Hospital Director, Medical Director and the Finance Director, shall be placed before the Finance and Audit Committee that shall place the matter before the Board for final approval.

(j) The Finance Director will report in the case of day-to-day matters to the Hospital Director and Medical Director as relevant.

(5) **Evaluation**: The Board shall monitor the performance of the Finance Director through objectively verifiable indicators itself or through a disinterested party on periodic basis. Such reports shall form the basis for continuation, termination or renewal of contract of the Finance Director.

V. GOVERNANCE STRUCTURE OF THE HOSPITAL

The Hospital will have an administrative management structure under the Hospital Director and a clinical management structure under the Medical Director (Appendix 1-2).

1. HOSPITAL EXECUTIVE COMMITTEE

(1) The Hospital Director will head a Hospital Executive Committee consisting of the Heads of all the departments under his/her authority, including Nursing.

(2) The Hospital Executive Committee will meet on a monthly basis under the Chairpersonship of the Hospital Director to discuss and resolve issues with Hospital non-clinical functions such as space, building maintenance, information services, procurement and materials management, patient flows, parking, etc.

2. NURSING DEPARTMENT

(1) The nursing department organizational structure is shown in Appendix 3.

(2) A Nursing Advisory Committee, consisting of all nurse managers will meet on a monthly basis, under the chairpersonship of the Nursing Director, to review and discuss current nursing functions and plan future nursing programs and expansions.

3. MEDICAL COLLEGE/ INSTITUTES

(1) FPGMI, SFINHS, SKZMDC, their faculty and support staff will function under the Dean, as shown schematically in Appendix 4.

(2) The Deputy Deans will be selected by the Dean for approval by the Board.

(3) The Deputy Deans will

(a) Represent the Institute at relevant administrative and educational fora;

(b) Undertake any other duties at the Institute assigned by the Dean.

(c) Oversee medical education in the College/Institutes and provide reports at regular intervals to the Academic Council,

(d) Assist in the recruitment of house staff for the Institutes

(e) Perform such other functions as prescribed by the Dean and Academic Council.

(f) The Dean may abolish or add any functions to the Deputy Deans as they deem fit.

4. ACADEMIC COUNCIL

(1) The Dean will be advised by an Academic Council, of which she/he will be Chairperson as mentioned in Section 10(5) of the FMTI Act.

(2) The Academic Council will consist of the Heads of all the academic departments, plus Deputy Deans.

5. CLINICAL EXECUTIVE COMMITTEE

(1) A Clinical Executive Committee will be formed to advise the Medical Director on all clinical matters,

(2) It will consist of the Medical Director as Chair, Medical Department heads, Nursing Director with the Hospital Director and Manager Quality Assurance as ex-officio members.

(3) It will review any current clinical hospital-wide clinical problems;

(4) It will monitor and ensure the highest quality of medical care at the Hospital;

(5) It will advise and develop clinical performance metrics;

(6) It will plan future clinical development and programs for the Hospital;

(7) It will recommend corrective actions for individuals and departments;

(8) It will appoint a Clinical Privileges Committee as noted in the Medical Staff Bylaw 7.3 (Appendix 7)

(9) The Medical Director will inform the Board of the progress about initial implementation within three (3) months and then report periodically as determined by the Board.

VI. GENERAL REGULATIONS FOR ALL EMPLOYEES OF THE SZPGMI

1. EMPLOYEE CONDUCT

(1) The general conduct expected of an employee is detailed in the Employee Handbook (Appendix 6) which will be given to each employee on joining service with the SZPGMI and will also be published on the SZPGMI official website.

(2) Employees are expected to uphold the highest standards of integrity, honesty, compassion and goodwill towards patients and their co-workers.

(3) Employees will, upon joining the SZPGMI, receive an Orientation to the Institution, its functions, and the expected Code of Conduct by the HR department.

(4) All employees, upon joining the SZPGMI will sign a document indicating their full understanding and acceptance of the Hospital Code of Conduct, receipt of a copy of the Employee Handbook, and their understanding of the same.

2. WORKING HOURS FOR SZPGMI STAFF

(1) Regular working hours for employees will be from 8:00 am to 3:00pm Monday to Thursday and Saturday. On Fridays, the regular working hours shall be from 8:00am to 12:00pm.

(2) However, timings may vary for employees working in shift-based departments as the Hospital works in three shifts. Shift timings will be notified separately as per requirement of the departments.

(3) Employees shall observe working hours as determined by their departmental manager or supervisor.

(4) Provided that medical staff, including consultants, and house staff, and essential staff may be required to attend at weekends and nights as determined by the department head and the Medical Director, in order to provide complete medical service to patients at all times. Such attendance would be on a roster basis, ensuring that each medical staff member is treated equitably and sufficient consideration given to avoid excessive overwork.

3. INSTITUTIONAL PRIVATE PRACTICE

(1) Employees who opt for institutional private practice may be entitled to such increase in salary, adjustment, bonuses or other ancillary benefits, as the Board may approve.

(2) Employees, who do not opt for Institutional private practice within the premises of the hospital's clinics, imaging facilities and laboratories of the SZPGMI, shall not be entitled to any increase and adjustment, incentives, bonuses or other ancillary benefits or administrative posts, except in case of extraordinary need, as decided by the Board.

(3) Consultants professional fee shall not exceed the usual and customary fees charged for the same services in the community, assuring efficiency, and value for money to the clients.

(4) Private patient billing shall consist of the professional fee component and the Institutional charges representing the charges of the clinic, imaging facility, laboratory services, or other Institutional charges. Provided that all patient billing shall be done only by the hospital, clinic, imaging facility, or laboratory, and the professional fee component shall be paid to the Consultant.

(5) No reduction of the professional component income to the Consultant from the patient shall be permissible by the SZPGMI.

4. CIVIL SERVANTS

(1) All current employees recruited under SZPGMI Employees (Service) Regulations 1990 (amended 1992) who **have not opted** to become employees of the SZPGMI FMTI under Section 17(3) of the FMTI Act, shall be dealt with in such a manner as provided in Section 17(4) of the FMTI Act. They will be deemed employees of an attached department and **will be entitled to** all perks and privileges (**pension, gratuity, housing, health facilities, etc.**) as declared by the Federal Government from time to time.

(2) All current employees recruited under SZPGMI Employees (Service) Regulations 1990 (amended 1992) who **have opted** to become employees of the SZPGMI FMTI under Section 17(3) of the FMTI Act shall be subject to terms and conditions of employment as prescribed in these regulations. Such opting employees **will also be entitled** to post-retirement benefits and emoluments (**pension, etc.**) as per existing Federal Government laws and rules.

VII. EMPLOYEE RECRUITMENT

1. OVERVIEW

(1) For all other appointments in SZPGMI, apart from those of the Management Committee, the Board may delegate to the Dean, Hospital Director, Medical Director and Nursing Director, the process of recruitment of all personnel under their respective authorities, except that the Rules and Regulations will be followed in these selections and the principles of transparency, fairness and equity will be followed. The selection criteria and appointment process will be prepared and approved by the Management Committee.

(2) Final approval of all SZPGMI employees rests with the Management Committee. However, the Board has the right to review any appointment(s) as and when they may deem fit.

(3) Final approval of all medical faculty positions rests with the Dean. However, the Board has the right to review any appointment(s) as and when they may deem fit.

(4) The Board may also choose to review selected appointments of faculty and non-managerial positions level if they deem fit with the powers to cancel any appointment even after appointment is actualized in case an unfit candidate is selected for any slot. The Board will be kept informed of all appointments made by Dean and/or the Management Committee.

(5) For all new appointments there will be a minimum probationary period of three months, and upon satisfactory performance the contract may be renewed for the rest of the contract period as per rules.

(6) An employee of any component of the institute may be assigned work in other component(s). No additional emoluments will be paid for work carried out during normal working hours.

2. FACULTY RECRUITMENT

(1) The Board will delegate authority for recruitment and appointment of Medical faculty, both basic science and clinical, to the Dean.

(2) All appointments will be made solely on merit in a transparent and fair manner.

(3) At the initiation of the FMTI Act all existing faculty will continue in their current positions.

(4) The need for new faculty will be generated by the concerned Head of Department (“HOD”), with full justification and job description, indicating the level of the post (assistant professor, associate professor, etc.) along with the required qualifications/training/expertise if any, over and above those laid down for each level by the PMC, University and the College of Physicians and Surgeons of Pakistan.

(5) This will be discussed by the Academic Council and Dean and will be approved or disapproved.

(6) For an approved post, the Human Resources (“HR”) department will arrange to advertise as prescribed.

(7) The Board shall constitute a Selection Committee for selection of faculty which will consist of:

(a) Dean, Chair of the Selection Committee;

(b) Heads of Department ("HOD") of four (4) major specialties of the institute to be nominated by the Dean, Members;

(c) HOD of the concerned department, Member(s);

(d) A member of the Board to be nominated by the Chairperson of the Board;

(8) Suitable candidates will be invited for interviews by the Selection Committee;

(9) The Selection Committee will select entirely on merit, and in a fair and transparent manner after fulfilling the prescribed procedure

3. MEDICAL CONSULTANTS

(1) Medical consultants will be qualified physicians with MBBS or BDS degrees from recognized institutions or equivalent degrees and a higher diploma, such as FCPS, MRCP, FRCS, FRCPath, FRCR, FRCA or a US subspecialty Board diploma or equivalent and be licensed to practice medicine by the Pakistan Medical Commission (PMC).

(2) Medical faculty, duly recruited as in Regulations VII, Section 2, above, may be appointed as medical consultants to the Hospital.

(3) At the initiation of the FMTI Act, all medical consultants working at the Hospital will continue in their current positions.

(4) All medical consultant positions will be reviewed at least annually and their clinical privileges will be assessed by the Clinical Privileges Committee (see Appendix 7, Medical Staff Bylaw, 7.3) and duties may be assigned accordingly by the Medical Director in consultation with the Dean and HOD.

(5) New appointments to the Consultant Medical Staff will be on recommendation by the Dean and the relevant HOD to the Medical Director. Candidates will be clinical medical faculty appointed to the Medical College at senior Registrar or higher level.

(6) The Medical Director will submit the application to the Clinical Privileges Committee ("CPC") for approval and assignment (see Appendix 7, Medical Staff Bylaw 7.3)

(7) In the case of rejection of a candidate by the CPC, a full written report indicating the rationale for the rejection will be provided to the Medical Director who will forward it to the Dean.

(8) In the event of disagreement between the Medical Director and the Dean, the matter may be referred to the Board for a final decision.

4. DEPUTATION

(1) The appointment of a person/civil servants on deputation to the institute from the Federal or a Provincial Government Department or a local body or an organization set up by or under such a Government shall be subject to the approval of the Board.

(2) An employee who is a civil servant, shall be liable to serve in any post outside the Institute on deputation as may be agreed by mutual consent, provided that his terms and conditions as to pay and allowances shall not be less favourable than those which he would have drawn from time to time if he had not been so required to serve.

5. RECRUITMENT OF HOUSE STAFF

(1) The Dean and Medical Director may oversee the recruitment, training and performance of trainee postgraduate doctors and non-faculty doctors (House Officers/Senior House Officers/Trainee Registrars/Medical Officers) for SZPGMI.

(2) A joint induction Committee comprising of Deputy Deans/HODs and headed by the Dean as its chair, shall be constituted to oversee the process of induction.

(3) The SZPGMI will have the right to designate the number of posts available for trainees in any specialty up to the maximum number approved.

6. RECRUITMENT OF NURSING STAFF

(1) Nursing Director may oversee the recruitment, training and performance of nurses for SZPGMI;

(2) A joint Selection Committee comprising of HODs of Clinical Departments and headed by the Nursing Director as its chair, shall be constituted to oversee the process of selection.

7. RECRUITMENT OF PARAMEDICAL STAFF

(1) Dean/Hospital Director may oversee the recruitment, training and performance of paramedical staff for SZPGMI.

(2) A joint Selection Committee comprising of HODs and headed by the Dean/Hospital Director as its chair, shall be constituted to oversee the process of selection

8. RECRUITMENT OF ADMINISTRATIVE/NON-MEDICAL SUPPORT STAFF

(1) Dean/ Hospital Director may oversee the recruitment, training and performance of paramedical staff for SZPGMI.

(2) A joint Selection Committee comprising of HODs and headed by the Dean/Hospital Director as its chair, shall be constituted to oversee the process of selection.

VIII. EMPLOYEE PROMOTIONS

1. FACULTY PROMOTION

(1) Faculty at assistant professor or associate professor level will be considered for promotion to the next level at eight (8) years or less from the time of initial appointment in the post.

(2) The promotion requirements at each level will be as criteria recommended for that level by the PMC or as decided by the Academic Council and the Board, provided that all promotions will be based entirely on merit and meet minimum PMC standards.

(3) The initial decision to proceed with promotion is to be made by the HOD at the departmental level, by the Departmental Promotions Committee, except at the 8th year when the promotion process must proceed regardless

(4) Provided that those senior registrars, assistant and associate professors who have already served five (5) or more years in the post as of Mar 2022 will have a maximum of three (3) years from October 1st, 2022 to be considered for promotion as in Regulation VIII, Section 1(1) above.

(5) The candidate's dossier, if approved by the Departmental Promotions Committee, will be presented to the Institutional Promotions Committee.

(6) If approved by the Institutional Promotions Committee, the candidate will be promoted and the Board so informed.

(7) If not approved, the candidate may apply again in the subsequent year, provided that a post was available for promotion.

(8) Provided that a candidate for promotion from Associate Professor to full Professor who is unsuccessful may continue in his post and apply again within two (2) years. In the event of disapproval for a second time, the candidate's employment contract may not be continued.

2. INSTITUTIONAL PROMOTIONS COMMITTEE

(1) The Dean will appoint an Institutional Promotions Committee consisting of seven (7) members of the faculty at Professor level and the Medical Director but excluding the HOD of the candidate's department.

(2) The Dean will appoint a chair of the committee from amongst the members. The Dean may not nominate himself nor be a member of this committee.

(3) The tenure of members of the committee will be five (5) years, at the end of which period the Dean will appoint new members, provided that an existing member's term may be renewed for one more term. No member may be appointed to the committee for more than two (2) successive terms.

(4) The committee will receive the promotion recommendation from the departmental promotions committee and make a final decision which will be provided in writing detailing the reasons for the decision to the HOD of the candidate's department.

3. DEPARTMENTAL PROMOTIONS COMMITTEE

(1) The faculty members in each department will form a Departmental Promotions Committee, chaired by the HOD and consisting of all departmental faculty members above the rank of the individual being considered for promotion. Thus for a candidate for promotion from assistant to associate professor, all departmental faculty who are associate or full professors will form the committee, whereas for a candidate for promotion from Associate to Full Professor, only faculty members who are full professors will form the committee.

(2) The committee will consist of at least three (3) members, including the HOD

(3) In the event that there are insufficient requisite faculty members in a Department, the Dean will invite faculty members of appropriate rank from other departments to complete the minimum requirement of three members.

4. APPOINTMENT OF HEADS OF DEPARTMENT

(1) The Dean will form a search committee to recommend candidates for the post of each HOD. The committee will consist of one faculty member from the concerned department and four faculty members from different departments. The committee will also include the Medical Director or his/her nominee. The Dean will appoint a chair from amongst the members of the committee. The search committee will invite applications and proceed in the prescribed manner.

(2) The committee will make its recommendation to the Dean who may accept or reject it. In the event of rejection, the Dean will provide a written explanation for his action to the search committee, which will then proceed to recommend another candidate following the procedure mentioned above.

(3) HODs will serve for a term of three (3) years renewable for two (2) further terms of three (3) years each at the discretion of the Dean based upon performance and so documented by the Dean. No person may serve as HOD for more than three (3) consecutive terms.

5. NON-FACULTY PROMOTIONS

(1) Promotions will be based on length of service and performance evaluation reports.

(2) Non-Faculty Promotion Committee will be nominated by the relevant member of the Management Committee and approved by the Management Committee

(3) The Non-Faculty Promotion Committee will consist of at least three (3) members

(4) The Non-Faculty Promotion Committee will make its recommendation to the Dean who may accept or reject it. In the event of rejection, the Dean will provide a written explanation for his action to the Non-Faculty Promotion Committee, which will then proceed to recommend another candidate following the procedure mentioned above.

IX. EMPLOYEE GRIEVANCE PROCEDURE

(1) All employees of a Medical Teaching Institution, except the Dean, Hospital Director, Medical Director, Nursing Director and Finance Director, shall have the right to appeal against any penalty, censure or termination of their employment to the Board.

(2) The aggrieved employee should appeal within 30 days of the Adverse action and the Board shall decide within 90 days.

(3) Any employee aggrieved by a decision of the Board may seek resolution of the grievance by referral of the grievance or dispute to the Appellate Tribunal for Medical Teaching Institutions. The decision of the Appellate Tribunal shall be final in all respects.

X. DISCIPLINARY PROCEEDINGS

In the event that an employee is suspected to have committed an infraction of the SZPGMI Rules and Regulations and policies, or the expected code of conduct, or violation of the employment contract, or the ethical obligations for medical staff, or other illegal activity, or inefficiency, or misconduct, an enquiry may be instituted as per SZPGMI Disciplinary Policy (see Appendix 9).

XI. BUDGETARY PROCESS

(1) The annual budget development process is shown in Appendix 5

(2) Annual Budgets will be prepared separately by the Federal Postgraduate Medical Institute, Shaikh Zayed Hospital, Shaikha Fatima Institute of Nursing and Health Sciences and Shaikh Khalifa Bin Zayed Al-Nahyan Medical and Dental College.

(3) These budgets will be prepared by a process whereby every department and division will submit an annual budget, to include capital equipment and expenses, to the Finance Director of SZPGMI.

(4) These budgets will be reviewed, adjusted and forwarded to the Dean in the case of the Medical College/Institutes, and to the Hospital Director and Medical Director in the case of the Hospital.

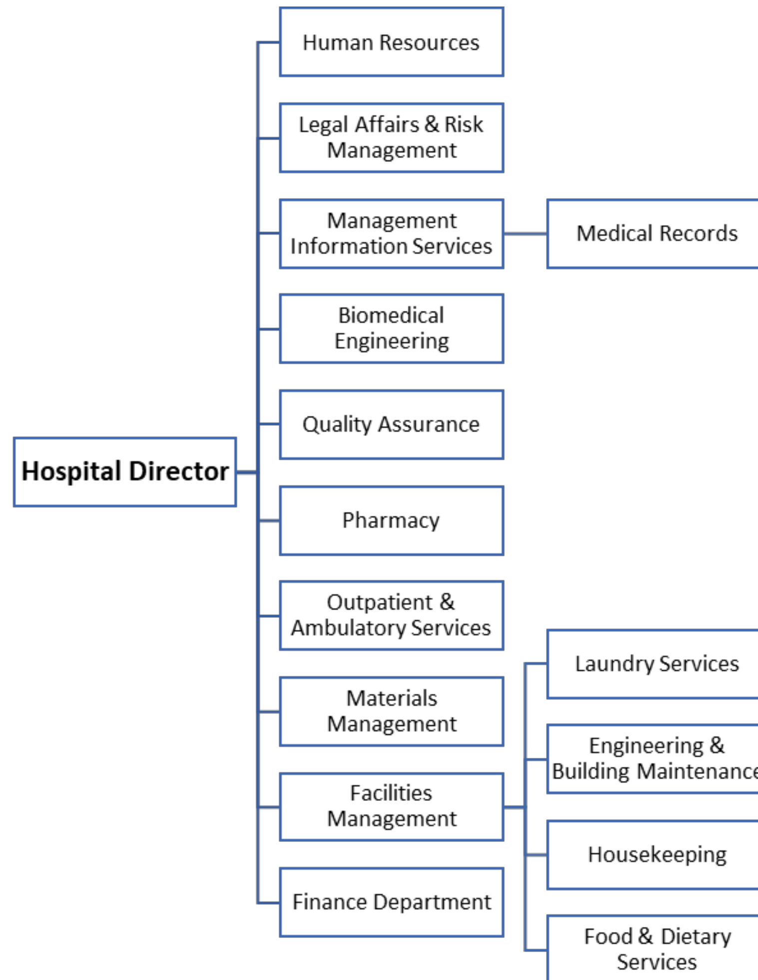
(5) These approved budgets will then be submitted to the Management Committee for approval, and thence to the Finance and Audit Committee.

(6) The Finance and Audit Committee will review the budgets and recommend an approval or revision to the Board. The Board will then approve the final budgets.

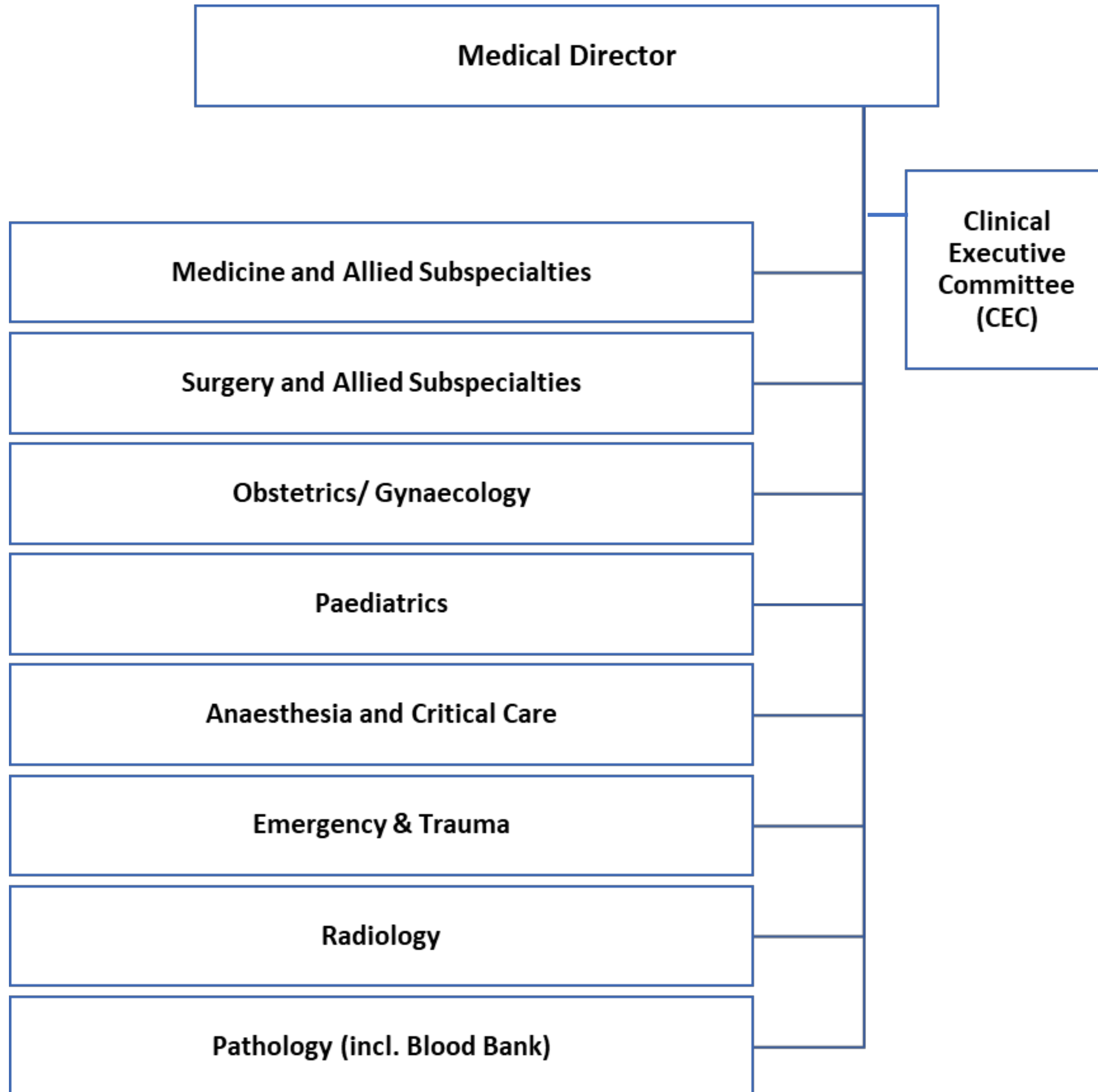
(7) Once the budgets are approved by the Board, each Component (FPGMI, SFINHS, SKZMDC, SZH) will proceed to utilize their funds according to the approved budget – no further approvals will be required, as long as the expenditure is according to the approved budgetary plan.

(8) At the end of each fiscal year, the financial performance of each Component may be reviewed and audited by the Board to ensure that the approved budget allocations were appropriately followed, as well as to ensure that all financial processes were transparent and ethical.

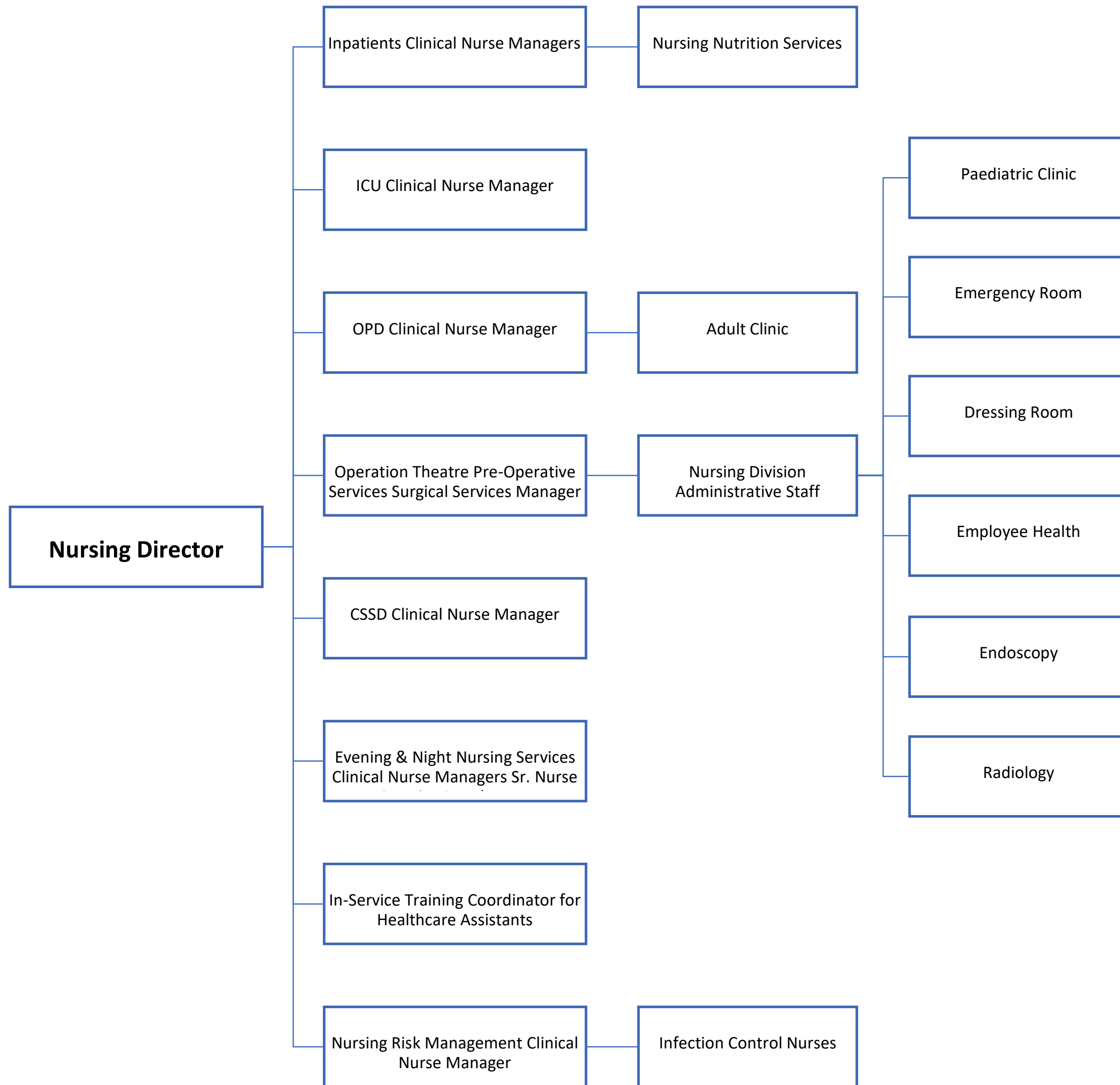
XII. APPENDIX 1: HOSPITAL ADMINISTRATIVE STRUCTURE



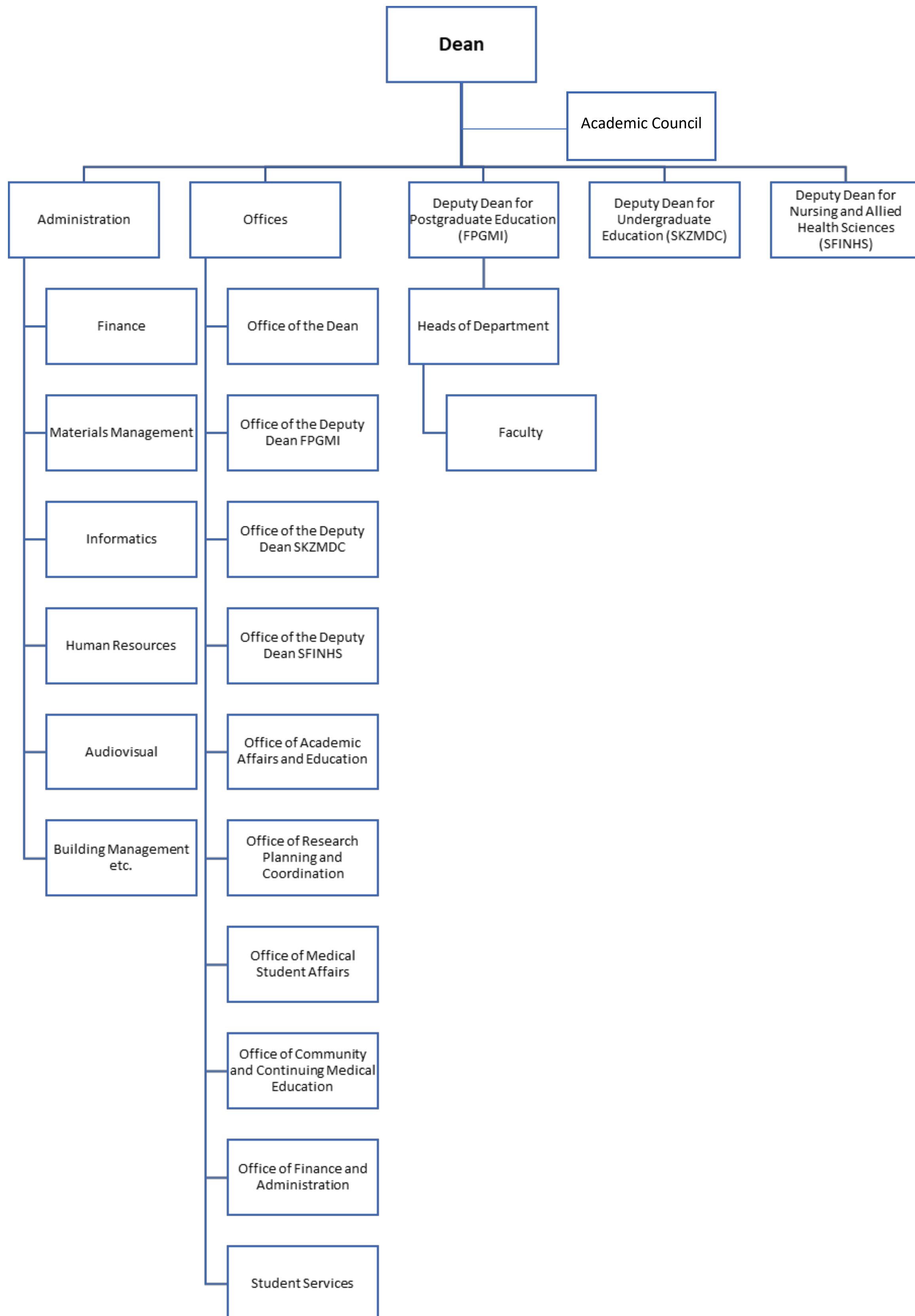
XIII. APPENDIX 2: MEDICAL STRUCTURE



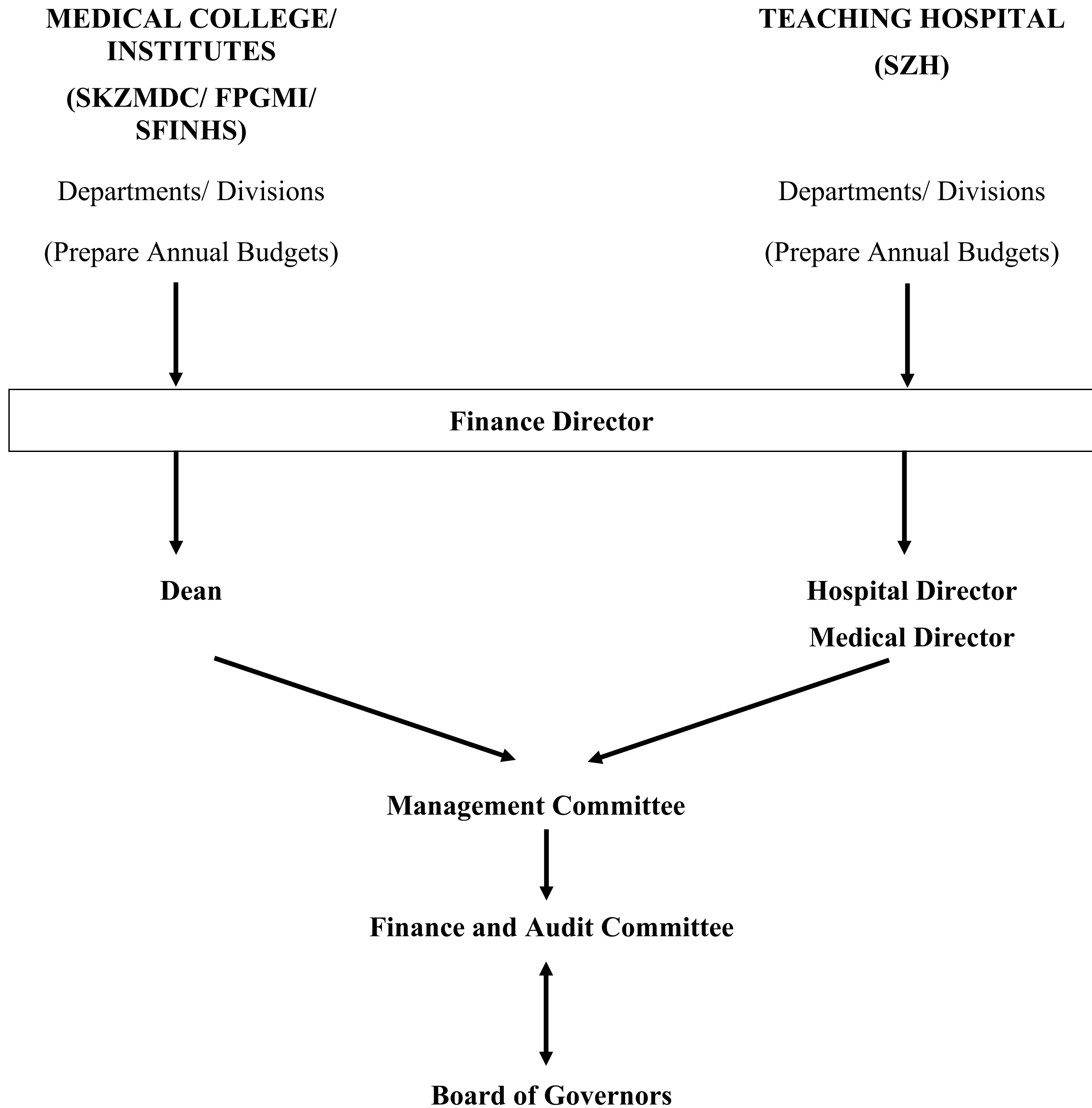
XIV. APPENDIX 3: NURSING STRUCTURE



XV. APPENDIX 4: ACADEMIC STRUCTURE



XVI. APPENDIX 5: ANNUAL BUDGETARY PROCESS



XVII. APPENDIX 6: EMPLOYEE HANDBOOK

This handbook is a resource guide and summary of the Institution's services, rules and regulations, and benefits available and applicable to its employees. Employees should read this handbook and use it as a reference guide. If further clarifications are needed, employees should contact their supervisor or the Human Resources Department.

Table of Contents

ORGANISATIONAL STRUCTURE

INSTITUTIONAL CULTURE & ETHICS

CODE OF CONDUCT AND BEHAVIOUR

GENERAL POLICIES

EMPLOYEE BENEFITS AND FACILITIES

SAFETY AND SECURITY MEASURES

IMPORTANT TELEPHONE NUMBERS

SITE PLAN AND FLOOR MAPS

1. ORGANISATIONAL STRUCTURE

The SZPGMI consists of the Federal Postgraduate Medical Institute, Shaikh Zayed Hospital, National Institute of Kidney Disease (Workers Welfare Foundation Block), Shaikh Fatima Institute of Nursing and Health Sciences and Shaikh Khalifa Bin Zayed Al-Nahyan Medical and Dental College, that would function under the overall control of the Board of Governors:

Institutional Organization

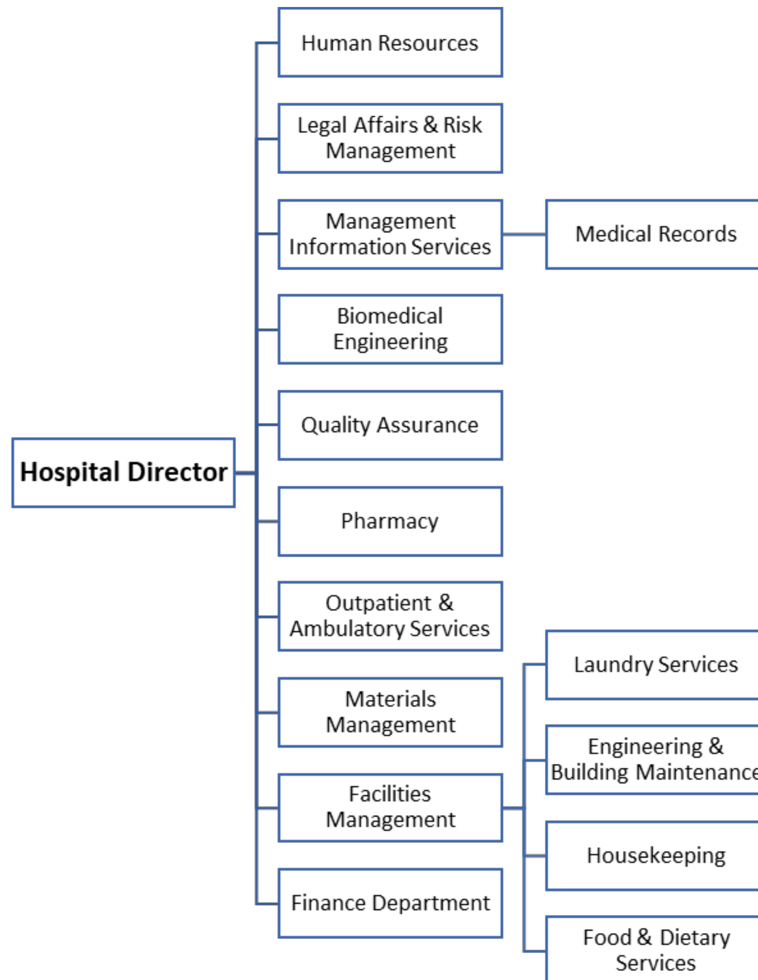
Federal Government

Board of Governors

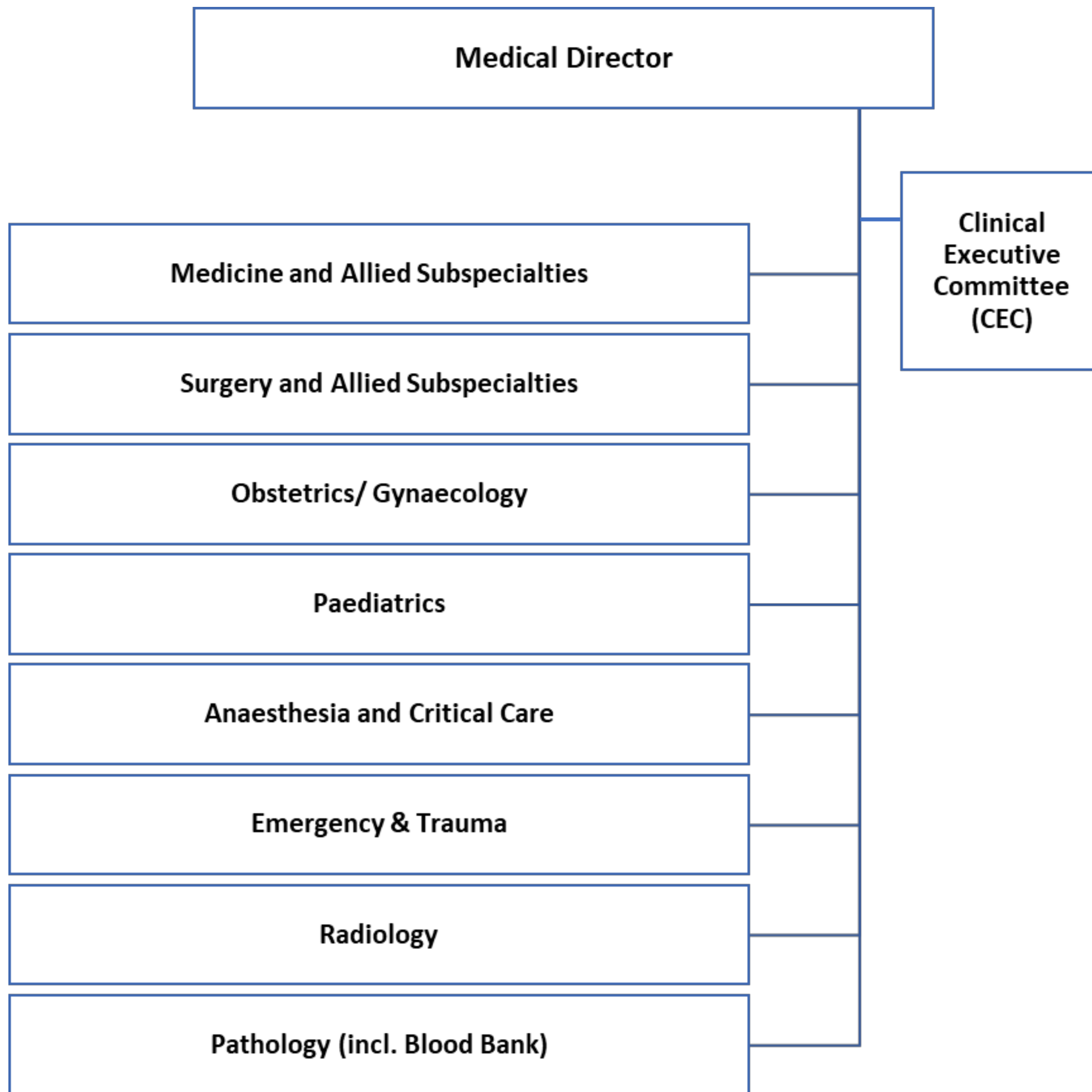
Hospital Management Committee

Dean SZPGMI	Chairperson
Hospital Director	Member
Medical Director	Member
Nursing Director	Member
Finance Director	Member
Any two other persons appointed by the Board on the recommendation of the Dean	Members

Hospital Administrative Structure



Medical Structure



2. INSTITUTIONAL CULTURE, ETHICS AND PHILOSOPHY

The Institution is committed to providing the best possible care for its patients and the best possible teaching for its students, both undergraduates and postgraduates, guided by the principles of equity, transparency and merit in all activities, and striving towards continual quality improvement.

3. CODE OF CONDUCT & BEHAVIOUR

(1) Discipline and General Conduct

An employee shall conform to and abide by the rules and regulations of the Institute and carry out all directives (as applicable according to the rules and regulations of the Shaikh Zayed Postgraduate Medical Institute) which may from time to time be given to him by the person under whose jurisdiction, superintendence or control he may be placed.

An employee shall make utmost endeavour to promote the interest of the Institute and shall show due courtesy and attention in all transaction with the Government and public.

An employee shall not make a personal representation to any member or the Board of Governors or any other authority. Such a representation must be addressed to the competent authority through the immediate superior of the employee.

An employee shall not absent himself from duty, not leave his headquarter without first having obtained the permission of the competent authority.

(2) Private Trade, Employment or Work

No employee shall, except with the previous sanction of the competent authority, engage in any trade or undertake any employment or work other than his official duties; provided that he may without such sanction, undertake honorary work of a religious, social or charitable nature or occasional work or a literary or artistic character, subject to the conditions that his occupation or undertaking does not conflict or is not inconsistent with his position or obligations as an employee of the Institute.

This clause shall not be construed to include the private practice of the consultant medical staff.

Notwithstanding anything contained in sub-regulation (a), no employee shall associate himself with any private trust, foundation or similar other institution which is not sponsored by the Government.

(3) Intimation of Involvement and Conviction in Criminal Case

If any employee is involved as an accused in a criminal case, he shall bring the fact of such involvement or conviction, as the case may be, to the notice of the Competent Authority of the Institute immediately or if he is arrested and released on bail, soon after such release.

(4) Unauthorized Communication of Official Documents or Information

No employee shall, except in accordance with any special or general order of the Institute, communicate directly or indirectly any official document or information to another employee unauthorized to receive it or to a non-official person or to other persons.

(5) Taking Part in Politics and Election

No employee shall take part in or subscribe to or assist in any way in any political movement in Pakistan or relating to the affairs of the Government.

No employee shall permit any person dependent on him for maintenance or under his care or control to take part directly or indirectly to be subversive of Government as by law established in Pakistan.

No employee shall canvass or otherwise interfere or use his influence in connection with or take part in any election to a legislative body, whether in Pakistan or elsewhere. Provided that an employee who is qualified to vote at such an election may exercise his right to vote; but if he does so, he shall give no indication of the manner in which he proposes to vote or has voted.

(6) Approach to Members of the Assemblies etc.

No employee shall, directly or indirectly, approach any member of the Senate, National Assembly or a Provincial Assembly or any other non-official person to intervene on his behalf in any matter.

(7) Use Political or Other Influence

No employee shall bring or attempt to bring political or other outside influence, directly or indirectly, to bear on the Board or its member or any officer or employee thereof, in support of any claim arising in connection with his employment including matters relating to appointment, promotion, transfer, punishment, retirement or other conditions of service.

(8) Management etc. of Newspaper or Periodicals

No employee shall, except with the previous sanction of the Board, own, wholly or in part, or conduct or participate in the editing of management of the newspaper.

(9) Radio Broadcasts or Television Programme and Communication to the Press

No employee shall, except with the previous sanction of the Board, or in the bonafide discharging of his duties, participate in a radio broadcast, television programme or social media broadcast or contribute any article or write any letter, either anonymously or his own name or in the name of any other person to any

newspaper or periodical. Provided that no sanction shall be required if such broadcast or television programme or such contribution or letter is of a purely literary, artistic or scientific character.

(10) Publication of Information and Public Speeches Capable of Embarrassing the Government

No employee shall, in any document published, or in any communication made to the press, over his own name, or in any public utterance or television programme or any other radio/social media broadcast delivered by him make any statement of fact or opinion which is capable of embarrassing the Government or SZPGMI. Provided that technical staff may publish research papers on technical subjects, if such papers do not express view on Government policy and not include Information of a classified nature.

(11) Evidence Before Committee

No employee shall give evidence before a public committee except with the previous sanction of the Dean.

No employee giving such evidence shall criticize the policy or decision of the Federal or a Provincial Government.

This regulation shall not apply to giving evidence before a committee powered by law to compel attendance and the giving of answers, or to evidence giving in judicial inquiries.

(12) Propagation of Sectarian Creeds etc.

No employee shall propagate such sectarian creeds or take part in such sectarian controversies or indulge in such sectarian partiality favouritism as are likely to affect his integrity in the discharge of his duties or to embarrass the administration or create feelings of discontent or displeasure among the employees of the Institute in particular and among the people in general.

(13) Nepotism, Favouritism and Victimization

No employee shall indulge in provincialism, parochialism, favouritism, victimization and wilful abuse of office.

(14) Membership of Non-Political Association

No employee shall accept membership of an association or organization whose aims and object, nature of activities are not publicly known.

(15) Approaching Foreign Missions and any Aid Giving Agencies

No employee shall approach directly or indirectly a foreign mission in Pakistan or any foreign aid-giving agency to secure for himself invitation to visit a foreign country o to elicit officers of training facilities abroad.

(16) Gifts

No employee shall, except the previous sanction of the Board, accept or permit any member of his family to accept, from any person any gift the receipt of which will place him under any form of official obligation to the donor.

If any question arises whether receipt of a gift places an employee under any form of official obligation to the donor the decision of the Dean thereon shall be final.

(17) Gifts or Payments to the Institution

Friends, donors, vendors, distributors, manufacturers, pharmaceutical companies or others may offer to donate money, goods or equipment to the Institution. The authorized department to receive all such gifts and donations is the Finance department, which has instructions on how to handle and accept gifts. All such offers should be referred to them. As always when in doubt please consult your supervisor.

(18) Rebates, Commissions, Discounts, Special Deals

In purchases for the Institute, all rebates, discounts, commissions, special price reductions, volume discounts, prizes, coupons or any other benefit belong to the Institute. Vendors may offer such benefits to employees, sometimes clothed as educational or developmental activity or other euphemism. Receiving any such benefit is unethical and illegal and would be grounds for disciplinary action up to and including termination of services. Any offer to you of such benefits must be reported to your supervisor.

(19) Conflict of Interest ("COI")

A Conflict of Interest ("COI") is a situation in which an employee may benefit personally from a decision or action of the Institution over which he/she has influence. For example, the ability to leverage or influence Institutional decisions that may directly or indirectly benefit the decision maker is a *conflict of interest* situation. Another example is having significant or controlling business interests in entities that do business or compete with the SZPGMI.

Conflicts of interest can exist in many situations and can be mitigated by declaring them to your supervisor who needs to document it in your record. If you are unsure, it is better to be cautious and declare a potential conflict of interest, in writing, to your supervisor. Knowingly hiding a COI by an employee would be grounds for disciplinary action up to and including termination of services.

(20) Safeguarding and Protection of SZPGMI Property and Interests

Employees must be committed to protecting and safeguarding the physical, intellectual and other interests of the Institution and your conduct should reflect this.

(21) Use of Intemperate Language/Baseless Accusations

At times, representations of employees contain wild allegations against superior officers. While employees are free to submit their representations in accordance with the prescribed procedure whenever they feel aggrieved, they are informed that the use of such language constitutes misconduct. All employees must, therefore, refrain from the use of such language and to scrupulously observe the norms of decency and decorum. Failure to do so on their part will not only result in no action being taken on requests contained in such representations/petitions but will also render them liable to disciplinary action for misconduct. Serious action will also taken when wild allegations are made against senior officers which, on investigations, are found to be without any basis.

4. GENERAL POLICIES

(1) Patient Confidentiality

All records and information acquired by you through your professional duties are highly confidential and should be protected. They should be used only in your professional capacity to provide proper care. It is strictly prohibited to discuss any patient with anyone except members of the treatment team. Anyone breaching patient confidentiality will receive immediate disciplinary action, which may include termination of employment.

(2) Whistleblowing Policy

The Institution is committed to the highest possible standards of openness, integrity, and accountability. The Institution therefore expects and encourages its employees having genuine concerns about any aspects of the Institution’s work, to come forward and voice those concerns without the fear of reprisal and victimization. In this regard the employee should first voice their concerns to their supervisor or Human Resources Department.

(3) Working Hours

Regular working hours for employees will be from 8:00 am to 3:00 pm, Monday to Thursday and Saturday. On Fridays, the regular working hours shall be from 8:00am to 12:00pm.

However, timings may vary for employees working in shift-based departments as the SZPGMI works in three shifts. Shift timings will be notified separately as per requirement of the departments.

Employees shall observe working hours as determined by their departmental manager or supervisor.

Provided that medical staff, including consultants, and House Staff, and essential staff may be required to attend at weekends and nights as determined by the department head and the Medical Director, in order to provide complete medical service to patients at all times. Such attendance would be on a roster basis, ensuring that each medical staff member is treated equitably and sufficient consideration given to avoid excessive overwork.

(4) Punctuality

Employees must arrive for work punctually and remain at work during their normal working hours. Persistent lateness, or unexplained absenteeism, will lead to disciplinary action.

(5) Orientation

The Human Resources Department will design an orientation program to familiarize employees with the Institution and provide important information related to working here. All new employees will be required to attend the orientation program before reporting to work. Departmental orientation, which includes orientation to specific job duties, responsibilities, expectations, safety procedures, and departmental policies and procedures, will be provided by each employee's supervisor.

(6) Joining Report

All new employees should fill and submit the duly completed Joining Report to the Human Resources Department within two days of joining the institution. This Joining Report enlists the employee in SZPGMI Information System and payroll.

(7) Dress Code

All employees must be well-groomed, clean and wear appropriate clothes.

(8) Uniforms

Employees required to wear uniforms should be dressed in their uniforms designated by the SZPGMI at all times during working hours. The department managers will be responsible for monitoring this and may request the employee to return home if they are not appropriately dressed. Employees must keep their uniforms in immaculate condition in order to project a good image of the Institution.

(9) Employee ID Cards

Each employee is required to wear the ID card at all times while working in the Institution. Wearing an ID Badge will

(a) Ensure a secure environment for employees and visitors.

(b) Protect the Institution's physical and intellectual property.

(c) Control access to unattended areas of the facility.

(d) Track employee time and attendance.

(e) Project an appropriate image to clients, vendors and other stakeholders.

(f) Track visitors in the facility.

(10) Attendance/Identity Card Procedure

Each employee will receive a SZPGMI Identity Card with a unique employee code number. Attendance is marked through this SZPGMI Identity Card and/or Biometric Thumb Impression (whichever method has been adopted by the Management Committee), once at the time of entry and the second on exit. In case the Institute's network is down and cards cannot capture your attendance, or you have lost your SZPGMI Identity Card, a Time Adjustment Form must be completed. Salary payment depends upon the attendance record. In case of loss of the SZPGMI Identity Card, report the loss immediately to the Human Resources Department by completing a Lost ID Card Form

(11) Performance Appraisal

A performance appraisal is carried out at on an annual basis in an employee's career. The evaluation criteria will be prepared by the Management Committee and approved by the Board.

Appraisal meetings will be private, providing for an honest and open discussion of the employee's work performance. This discussion will include, if applicable, recommended methods of improvement, and recommendations for additional trainings, recommendations for retention, promotions, and salary reviews. Evaluations will be signed by the employee and the department head and will be forwarded to the Human Resources Department for review and be kept on record.

(12) Resignation Procedure

In case an employee wishes to resign from the SZPGMI, she/he will submit a resignation letter to the Component Head through the Department Head, as per the terms and conditions of his/her employment contract. The Human Resources Department will obtain clearance from all concerned departments mentioned in the clearance form, seek necessary approvals from the appointing authority and issue a letter of acceptance of resignation on the employee's last working day for clearance of his/her dues.

(13) Grievances and Disputes

Employees, have the right to raise concerns about their work, performance evaluation, including the way services are delivered and the care of patients, and to have those concerns dealt with in a prompt, fair and positive manner. This may occur through discussion, conciliation and, where necessary, formal grievance procedures. The formal grievance procedure consists of the employee filing a letter detailing the concern, to be submitted to the concerned Supervisor/Manager, with a copy to Human Resources Department. If the grievance is not settled at the managerial level the employee may appeal as per Regulation X (Employee Grievance Procedure).

(14) Smoking Policy

The Institution is a NO SMOKING ZONE. It is Institutional policy to prohibit smoking in all areas of the Institution, including its buildings and grounds. There will be no smoking by any employee, or visitor.

Smoking inside the College or Hospital is strictly prohibited in all lecture theatres, College buildings, offices, ambulatory care patients as well as all inpatients, including dining rooms, conference rooms, and Hospital grounds. Smoking in the Hospital premises may result in disciplinary action up to and including termination of employment. It is the employees' duty to ensure that visitors and patients also comply with the above policy.

(15) Alcohol and Drugs

Possession of or being under the influence of alcohol or drugs while on duty may result in immediate dismissal/termination from service.

(16) Firearms and Weapons

Firearms and weapons are strictly prohibited on the Institute's premises. Violators will be subject to immediate termination.

(17) Food

Eating food in working areas of the Institute is strictly prohibited. The Dining Hall and Visitor's Cafeteria are available for such purposes.

(18) Disciplinary Policy

Employees are expected to perform their duties diligently and to follow the prescribed Rules and Regulations and procedures and policies of the Institution. Willful non-observance or violation of these policies may lead to disciplinary action up to and including termination of services.

Employees will receive verbal, followed by written notice of a breach of the rules and policies and this will also be placed in their records. Depending on the seriousness and/or repetitiveness of the event, an inquiry will be instituted at the departmental level and the recommendations of the inquiry committee will be forwarded to the appropriate authority, for action.

5. EMPLOYEE BENEFITS & FACILITIES

(1) Pay

The basic pay scales prescribed by the Board shall be applicable to the employees of the Institute.

Pay on initial appointment shall be fixed at the minimum stage of the scale of pay provided in case suitable person of requisite qualifications/experience is not available on the minimum of the sanctioned pay scale of the post, the appointing authority may, for reasons to be recorded in writing, allow an appointment in higher pay scale.

The Board may decide it necessary to frame new and better pay scales for the employees of the Institute at any stage.

(2) *Overtime (applicable only to non-medical staff)*

The Institute may, at such rates and subject to such conditions as may be considered appropriate, grant overtime allowance to its employees. In such cases, written documentation of the overtime work performed, signed by both the individual and the supervisor is required.

(3) Earned Leave

Employees will accrue 3.5 days leave for every month worked, i.e. 42 days per year, excluding weekends.

(4) Ex Pakistan Leave

Earned leave may also be granted, as Leave Ex-Pakistan to an employee who applied for such leave or who proceeds abroad during leave.

(5) Casual Leave

Paid casual leave up to, but not exceeding 10 days per year may be granted with written justification by the Dean, Hospital Director or Medical Director, according to their respective authority, provided that Casual leave cannot be granted before six (6) months of continuous employment by the Institute.

(6) Extraordinary Leave (Leave without Pay)

Extraordinary leave without pay, up to a maximum of 120 days at a time, may be granted, on any grounds, with written justification by the Dean provided that Casual leave cannot be granted before six (6) months of continuous employment by the Institute.

(7) Sick Leave

Employees will be entitled to sick leave after 6 months of continuous employment by the Institution. Employees will accrue 1.5 days of sick leave for every month worked, for a total of 18 days per year. Utilization by the individual of sick leave will require a medical certificate documenting the sickness and inability to perform his/her duties. Sick leave cannot be accumulated from year to year.

(8) Maternity Leave

Female employees will be entitled to 45 days paid maternity leave before delivery and 45 days paid maternity after delivery, provided that such maternity leave will not be available to employees until after 4 months of continuous employment at the Institution. Maternity leave may not be granted more than three times in the entire service of a female employee. For confinements beyond third one, the female employee shall have to take leave from her normal leave account.

(9) Pension/Provident Fund

All employees may participate in the Institutional pension/provident fund. A voluntary deduction from the pretax salary will be matched by an equal contribution by the Institution to the individual's pension/provident fund.

(10) Medical Treatment/ Reimbursement

Free medical facilities to the extent available in the Hospital shall be admissible to all the employees of the Institute whether they are regular or on contract or employees on deputation. Employees will be entitled to medical care for themselves, their parents, their spouse, and unmarried dependent children, at SZPGMI.

Trainee doctors and students enrolled in various courses will be entitled to medical care for themselves only.

A detailed Medical Treatment/Reimbursement policy will be notified separately by the Management Committee, which may be modified from time to time.

(11) Career Development/Training

The Institute will provide career development and training, which may be practical, hands–on training and/or formal classroom teaching.

(12) Parking

Employees will be entitled to park on the premises of the Institute, at designated parking areas.

(13) Transport Facility

Transport facility may be provided for essential staff/assignments, if needed and approved.

(14) Travelling Allowance

An employee of the Institute shall be entitled to TA/DA on the rates as admissible to the Federal Government employees of a comparable status.

(15) Honorarium

The Dean my grant an honorarium not exceeding the basic pay in each case to an employee for special work performed by him which is occasional in character and either so laborious or of special nature as to justify a special reward.

6. SAFETY AND SECURITY MEASURES

(1) Life Safety Management

The Institution will establish processes for management of life safety. All employees, contract workers, volunteers, and medical staff members are required to actively participate in a fire drill. Also, all employees are responsible for understanding emergency procedures and emergency call codes:

(a) CODE BLUE is a Medical Emergency or Cardiac arrest.

The following procedure is to be adapted in case of patient cardiac arrest:

(i) Call [Insert number]

(ii) Wait for Code Blue Team

(iii) Guide the Code Blue Team to the patient immediately

(b) CODE GREEN is a Gas and Chemical Spillage.

Follow the same instructions as in (a) above

(c) CODE RED is a Fire Emergency or Bomb Threat

In case of a Code Red, an overhead announcement will take place when the entire building including all employees, visitors, attendants or patients must be evacuated.

Code Red Instructions

When you hear the fire alarm or code red announcement:

(i) Listen carefully to the instructions in the announcement.

(ii) Leave the building using the nearest emergency exit.

(iii) DO NOT run, push or overtake.

(iv) DO NOT use elevators as they are designated only for patients on wheelchairs or beds.

(v) Proceed to the designated assembly area.

(vi) DO NOT re-enter the building until advised by the Crisis Management Team.

Use RACE

R	RESCUE	"Rescue" people from the affected area
A	ALARM	Sound fire alarm and call Ext.[Insert Number]
C	CONFINE	Close doors to contain fire
E	EXTINGUISH	Only if trained to do so and if it is safe or evacuate the building

Evacuate Patients in the following order:

1. Patients who can walk

2. Patients on wheelchairs

3. Patients on beds

(2) Radiation Exposure

In case of a fire with a radiological emergency on a mass scale in the designated areas of Radiology, radiation exposure or contamination may harm those exposed. All those suspected of exposure to radiological contamination should stay at a safer place till assessed by Radiation Protection Personnel.

Radiation Protection Personnel (Radiation Protection Advisor, Radiation Protection Officers) along with fire-fighters will tackle such an emergency. Employees should not attend exposed area themselves.

(a) Call .... for Fire Fighting Team OR

(b) Call .... for Radiation Protection Personnel

Using PASS to Use a Fire Extinguisher

P	PULL	the pin
A	AIM	at the base of the fire
S	SQUEEZE	the lever
S	SWEEP	side to side

(3) Classification of Fire/ Methods of Extinguishing Fire

Classification of Fire	Description	Method of Extinguishing Fire
A Class Fire	***Solid Fire***: Fire of wood, furniture, stationery etc.	Use water and carbon dioxide to extinguish this type of fire.
B Class Fire	***Liquid Fire***: Fire of petrol, kerosene oil, paint, diesel etc. By covering the fire, reduction of oxygen will stop and extinguishing will take place quickly	Dust, Earth and foam are best to extinguish this fire.
C Class Fire	***Gas Fire***: Fire of gas	Cutting of supply is mandatory to extinguish this type of fire.
D Class Fire	***Metal Fire***: Magnesium, aluminum, sodium, titanium	AFFF is suitable to extinguish this type of fire.
E Class Fire	***Electricity Fire***: Electrical cabins, computers, multimedia, electrical switches and boards	Dry powder and carbon dioxide is suitable to extinguish this type of fire. Use water after switching off electricity supply

Emergency Assembly Areas – to be designated

Main: Lawn etc

7. EMERGENCY CONTACT NUMBERS

#	Description	Telephone Number
(i)	Security	(042) 35865731 Ext. 2213
(ii)	Fire Brigade	16
(iii)	Bomb Disposal	(042) 99212111
(iv)	Emergency Police	15
(v)	Rescue	1122
(vi)	Nearest Police Station	(042) 99230278

8. IMPORTANT PHONE NUMBERS

#	Description	Telephone Number
(i)	Main Telephone Exchange	(042) 3586573 – 6
(ii)	Dean's Office	(042) 35864218
(iii)	Deputy Dean FPGMI	(042) 99230717
(iv)	Deputy Dean SFINHS	(042) 99230724
(v)	Deputy Dean SKZMDC	(042) 35912308
(vi)	Hospital Director's Office	(042) 99230715
(vii)	Medical Director's Office	(042) 99230717
(viii)	Nursing Director	(042) 99230632
(ix)	Human Resources Department	(042) 35865731 Ext. 2268
(x)	Security Office	(042) 35865731 Ext. 2213
(xi)	**CODE BLUE** for Medical Emergency or Cardiac Arrest	Press – 9
(xii)	**CODE GREEN** for Gas and Chemical Spillage	Press – 9
(xiii)	**CODE RED** Fire Emergency or Bomb Threat	Press – 9
(xiv)	Transport Office (Ambulance Services)	(042) 35865731 Ext. 2203

9. SITE AND FLOOR PLANS

Available on the SZPGMI website as a separate document

XVIII. APPENDIX 7: MEDICAL STAFF BY-LAWS

1. PURPOSE

The purpose of the medical staff shall be to:

1.1. Ensure that all patients treated at the Hospital will receive efficient, timely, appropriate care that is subjected to quality improvement practices.

1.2. Ensure all patients being treated for the same health problem or with the same methods/procedures receive the same level of care. Establish, and assure adherence to, an ethical standard of professional practice and conduct.

1.3. Develop and adhere to facility-specific-mechanisms for appointment to the Medical staff and delineation of clinical privileges.

1.4. Provide educational activities that relate to: care provided, finding of quality of care review activities and expressed need of caregivers.

1.5. 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.

1.6. Assist the Board of Governors ("Board") in developing and maintaining rules for Medical Staff governance and oversight.

1.7. Bring the dimension of Medical Staff leadership to deliberations by the Hospital and Medical Directors and the Board.

1.8. Develop and implement continuous quality improvement activities in collaboration with the Institutional staff.

2. MEDICAL STAFF

2.1. Medical Staff Membership

2.1.1. Membership Eligibility

2.1.1.1. Membership on the medical staff is a privilege extended only to, and continued for, Medical Consultants appointed as per item (121) of the Functions and Powers Regulations.

2.1.1.2. 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:

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

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

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

2.1.2.4. 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 Regulations.

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

2.1.2.5. Abide by the FMTI 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

2.2.1.1. 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.

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

2.2.1.3. Shall satisfy the requirements set forth in 7.2.1.10 for attendance at meetings of the staff and of the department and committees of which the individual is a member.

2.2.1.4. 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 HOD of the appropriate department must be made to the Medical Director on a prescribed form.

2.2.2.1. 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 Committee (CEC) that the application be granted.

2.2.2.2. 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 Committee

iv. Shall be responsible to the HOD 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

2.2.3.1. These shall consist of residents and interns / medical officers (House Officers/ Senior House Officers/ Trainee Registrars/ Medical Officers), engaged in an approved course of training and education at the Institution, with or without compensation, and/or engaged for provision of care to the patients. Those recruited as noted in the Functions and Powers Regulations and others will be recommended for appointment by the Clinical Executive Committee, or by the Medical Director on behalf of the CEC, or by the respective department's HOD, for a limited period of training subject to the regulations of the Institution.

2.2.3.2. No formal list of clinical privileges shall be delineated for house staff, unless they are senior residents, designated by their department's HOD, 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.

2.2.3.3. 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.

2.2.3.4. Observer/Intern: A department may permit an outside physician/student to be an observer/intern without any patient care responsibilities.

2.3. Part-Time and Locum Consultant Staff

2.3.1. 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:

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

2.3.1.2. 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.

2.3.2. Locum Consultant Staff

2.3.2.1. A medical practitioner may be appointed to the Medical Staff on the recommendation of a HOD 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 Committee.

2.3.2.2. 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.

2.3.2.3. Members of the Locum Staff may attend CEC 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 recognized 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 behavior 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 and appropriate attire.

2.4.4. Academic Conduct

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

2.4.4.2. 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

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

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

2.4.4.5. 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

2.4.4.6. 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.

2.4.4.7. 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. APPOINTMENTS

3.1. Appointments

3.1.1. Medical Consultants

Medical Consultants will be appointed as noted in the Functions and Powers Regulations.

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

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

3.1.1.3. 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.

3.1.1.4. 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.

3.1.1.5. 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 Committee. 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.

3.1.2. Qualifications

3.1.2.1. HOUSE STAFF: Applicants for House Staff must meet the educational requirements of the institution.

3.1.2.2. ANCILLARY HEALTHCARE PROVIDER Applicants shall have their qualifications assessed pursuant to the provisions set forth in Appendix 7, Section 2.2.2.

3.1.2.3. 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 PMC for temporary registration to practice in Pakistan.

3.1.3. 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 HOD to the Medical Director, who will then make the final decision.

3.1.4. 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 Commission.

3.1.5. 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 Commission.

4. CLINICAL PRIVILEGES

4.1. Clinical Privileges

4.1.1. General Provision

4.1.1.1. 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.

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

4.1.1.3. 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.

4.1.1.4. Re-credentialing of each Medical Staff member and any other practitioner who holds clinical privileges is required every three (03) years. Re-credentialing 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. Re-credentialing is initiated by the practitioner's HOD at the time of a request by the practitioner for new and renewed clinical privileges.

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

4.1.1.6. A member of the Medical Staff who desires a change of privileges shall submit his request in writing to the HOD with full documentation to support the change. The HOD shall forward this request with his recommendations for consideration by the Clinical Privileges Committee.

4.1.1.7. 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.

4.1.1.8. 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.

4.1.1.9. 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.

4.1.1.10. 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 HOD. 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 HOD, 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:

4.3.1.1. Deficiency in any one or more of the criteria required for completion of the credentialing dossier.

4.3.1.2. Visiting physicians

4.3.1.3. Guest physicians coming for training programs

4.3.1.4. 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

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

i.

4.4.1.2. Initiation of Hearing

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

i. 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.

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

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

iv. 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.

v. 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.

vi. 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.

vii. 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.

viii. 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.

ix. Within three (3) 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

i. 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 Appendix 7, Section 4.4.1.1 (Right to Hearing), the Named Practitioner shall have the right of appeal of that decision.

ii. 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 CEC 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.

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

iv. Notice of Time and Place for Hearing of Appeal: Upon receipt of a timely request for appeal, the CEC 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.

v. The CEC shall be the authority to conduct hearing of appeals.

4.4.2.2. Appellate Procedure

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

ii. 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 CEC at least ten (10) business days prior to the scheduled date of the appeal, unless such time limit is waived by the CEC.

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

iv. 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 CEC, following an explanation by the party requesting the consideration of such matter or evidence as to why it was not presented earlier.

v. CEC 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.

vi. Presence of Members and Vote: A majority of the CEC 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.

vii. The CEC 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.

viii. Action Taken: CEC, 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. ORGANIZATION OF THE MEDICAL STAFF

5.1. Organization of the Medical Staff

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

5.1.2. 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.

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

5.2. Clinical Services

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

i. Department of Anesthesiology and Critical Care

ii. Department of Medicine and its subspecialties

iii. Department of Surgery and its subspecialties

iv. Department of Nuclear Medicine

v. Department of Pathology

vi. Department of Radiology

vii. Department of Pediatrics and its sub-specialties

viii. Department of Obstetrics and Gynecology

ix. Department of Emergency Medicine

x. Department of Dermatology

xi. Department of Ophthalmology

xii. Department of Otolaryngology

xiii. Department of Psychiatry

xiv. Department of Forensic Medicine

5.2.2. Number of Departments

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

5.2.2.2. The Hospital Director, the Medical Director, and the Clinical Executive Committee (CEC) after considering the recommendation of the Chair of the relevant department, may subdivide a department into sections, after approval from the Management Committee.

5.2.3. Characteristics

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

5.2.3.2. Holds regular meeting

5.2.4. Functions

5.2.4.1. 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.

5.2.4.2. 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.

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

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

5.2.4.5. 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 HOD of the relevant department in the Medical College/Institute or his designee. Where no such HOD or department exists in the Medical College/Institute (e.g the Blood Bank) the department Head will be appointed by the Medical Director based upon the recommendation of the CEC.

5.2.6. Duties and Responsibilities of Department Heads

Department Heads are responsible and accountable for:

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

5.2.6.2. 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).

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

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

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

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

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

5.3. Medical Staff Meetings

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

5.3.2. 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.

5.3.3. 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.

5.3.4. 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 chair for appropriate reasons, e.g. illness, leave, or clinical requirements.

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

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

6. SUB-RULES AND BY-LAWS

6.1. Amendments

6.1.1. The Medical Staff may recommend changes to these Medical Staff By-laws to the CEC provided they do not conflict with the FMTI Act or its Rules and SZPGMI Regulations and which shall be subject to approval of the Management Committee and final approval of the Board of Governors. Such approved changes shall become part of these Medical Staff By-laws.

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 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 CEC 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

6.8.1.1. 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.

6.8.1.2. Medical records shall not be removed from the Hospital.

6.8.1.3. 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.

6.8.1.4. 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

6.8.1.5. 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.

6.8.1.6. Physicians are obliged to familiarize themselves with the requisite components of the Final Notes and Operative Report.

6.8.2. Availability of Medical Records

6.8.2.1. 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.

6.8.2.2. 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.

6.8.2.3. 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.

6.8.2.4. 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.

6.8.2.5. Photocopying of a MR is prohibited, but it can be photocopied for an educational activity by concealing the patient's identification, thereby maintaining confidentiality.

6.8.2.6. Reviewers are expected to return the MR immediately if needed for patient care.

6.8.2.7. Please also refer to the Medical Records department's policy on 'Retention of medical records' in conformity with all statutory recommendations.

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:

6.8.3.1. Charts of discharged patients will be returned to the Medical Records Department within 24 hours of discharge.

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

6.8.3.3. 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.

6.8.3.4. 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.

6.8.3.5. 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

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

6.9.1.2. 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. 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.

6.12. Observers

6.12.1. Notwithstanding anything contained in the Regulations, an HOD 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.

6.12.2. 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.

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

6.13. 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.

6.14. Performance Appraisal Process

All members of the active medical staff are subject to an annual 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.

6.15. Suspension of Service

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

6.16. Privileges

6.16.1. 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.

6.16.2. 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.

6.16.3. 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.

6.16.4. 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.

6.17. Licensure

All members of the medical staff must hold a valid license issued by the Pakistan Medical Commission. 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 PMC. They may seek the assistance of the Medical Director in this regard.

7. COMMITTEES

7.1. Clinical Executive Committee (CEC)

Clinical Executive Committee ("CEC") will be structured and have the membership and functions as noted in Functions and Powers Regulations of the FMTI Act.

7.1.1. Duties of CEC

The Clinical Executive Committee shall:

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

7.1.1.2. Maintain a permanent record of its proceedings and actions

7.1.1.3. Make recommendations to the Medical Director concerning important matters that are referred from various sub-committees and patient care areas

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

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

i. For appointment of the Chair 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;

7.1.1.6. 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;

7.1.1.7. Advise the Medical Director on any matter referred to the CEC.

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

7.1.2. Notice and Agenda

Notice of a meeting of the CEC 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 CEC at least five days prior to the meeting.

7.1.3. Voting

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

7.1.4. Quorum

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

7.2. Standing Committees of the Clinical Executive Committee

7.2.1. Generic Terms of Reference for all Standing Committees

7.2.1.1. 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 CEC

7.2.1.2. The Medical Director shall name the Chair and membership

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

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

7.2.1.5. 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 CEC and/or the Hospital Director.

7.2.1.6. The Minutes of each meeting shall be forwarded to the CEC

7.2.1.7. 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.

7.2.1.8. The Chair is responsible for submitting an annual written report to the CEC.

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

7.2.1.10. 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 chair for appropriate reasons, e.g. illness, leave clinical requirements, etc.

7.2.1.11. Committee minutes will specify members absent, alternates and members present.

7.2.2. Standing Committees

7.2.2.1. Preamble

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

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

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

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

7.2.2.2. Names of Committees

A committee structure, staffed by a broad spectrum of health professionals and managers will be established. Such committees may 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

11. Blood Bank Committee

12. Hospital Safety Committee

13. Clinical Audits Committee

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

The Clinical Executive Committee shall form committees and draft Terms of Reference for their working and regularly supervise these committees. CEC may modify membership and TORs of a committee. It may recommend notification or de-notification of a committee to the Management Committee.

7.3. Terms of Reference of Committees

1. CLINICAL PRIVILEGES COMMITTEE (“CPC”)

Committee Mandate

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.

Membership

Chair	Medical Director
Member	Head Department of Medicine
Member	Head Department of Surgery
Member	Head Department of Pediatrics
Member	Head Department of Anesthesia
Member	Head Department of Radiology
Member	Head Department of Pathology
Member	Head Department of Radiation
Member	Manager Quality Assurance

Term	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
Secretary	Manager Quality Assurance will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Clinical Executive Committee (“CEC”)

Activities

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

Meeting Schedule	The CPC shall meet at least once every two months, or as determined by the Committee Chair.

2. QUALITY CONTROL COMMITTEE ("QCC")

On an as needed basis, representatives from other departments / Committees would be invited for their feedback.

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 Committee (CEC).

1.3 The QCC will establish an effective safety management program.

Membership

Chair	Medical Director
Co-Chair	Head Department of Medicine
Member	Nursing Director
Member	Representative from Department of Medicine
Member	Representative from Department of Surgery
Member	Representative from Department of Paediatrics
Member	Representative from Department of Anaesthesia
Member	Representative from Department of Radiology
Member	Representative from Department of Pathology
Member	Representative from Department of Obstetrics/ Gynecology
Member	Representative from Department of Psychiatry
Member	Manager Quality Assurance
Member	Quality Assurance Officer

On an as needed basis, representatives from other departments / Committees would be invited for their feedback.

Term	The Chair will serve for three years, while membership tenure will be for two years.
Secretary	Quality Assurance Officer will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Medical Director and the Clinical Executive Committee (CEC)

Activities

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:

a. Monitor and evaluate the quality of patient care

b. Monitor the clinical performances of individuals with delineated privileges

c. Identify and address opportunities for improvement and resolve important problems in patient care.

2) Discuss these reports/updates and send recommendations to the CEC

3) Review practice standards and criteria defined by all clinical departments

4) Set and monitor hospital-wide clinical quality assurance indicators

5) Identify trends against set standards in department/s and recommend appropriate corrective actions to the Clinical Executive Committee (CEC)

6) Submit monthly minutes to the Clinical Executive Committee (CEC) listing, activities, identified problems with recommendations, proposed solutions and alternative options

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.

Meeting Schedule The QCC shall meet at least once every month, or as determined by the Committee Chair

3. PHARMACY & THERAPEUTICS COMMITTEE (“P & T COMMITTEE”)

Introduction

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 P&T 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.

Committee Mandate

1) The P&T Committee is an advisory group composed chiefly of physicians and pharmacists and representatives from various departments of the hospital.
2) The P&T committee serves as the organizational line of communication between the Medical Staff and the Pharmacy Department.
3) The P&T 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.

Membership

Chair	Representative from Department of Internal Medicine
Member	Representative from Department of Medicine
Member	Representative from Department of Surgery
Member	Representative from Department of Paediatrics
Member	Representative from Department of Anaesthesia
Member	Representative from Department of Ophthalmology
Member	Representative from Department of Obstetrics/ Gynecology
Member	Representative from Department of Pathology
Member	Manager MMD
Member	Manager Pharmacy
Member	Representative from Nursing Department

Member	Manager Quality Assurance
Term	The Chair will serve for three years, while membership tenure will be for two years.
Secretary	Manager Pharmacy will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Medical Director and Hospital Director.

Activities

1) The primary purposes of the P&T Committee are:
    a. *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.
    b. *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.
    c. *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.
2) P&T Committee shall develop and approve a Drug Formulary for the hospital and provide for its continual revision and update.
3) P&T Committee shall evaluate suggestions of drugs/agents proposed for addition to/deletion from the hospital formulary.
4) P&T Committee shall minimize duplication of the same basic drug type.
5) P&T Committee shall recommend additions and deletions of drug stocked in the pharmacy.
6) The P&T Committee shall make and/or consider recommendations concerning drugs to be stocked in hospital patient units or services.
7) P&T Committee shall study problems related to the distribution and administration of medication.
8) P&T Committee shall recommend policies regarding the safe use of drugs in the hospital, including investigational drugs and hazardous drugs.
9) P&T Committee shall review adverse drug reactions in the hospital and recommend policies regarding the reporting of such reactions.
10) P&T Committee shall review drug utilization patterns and recommend policies for rational drug therapy in the hospital.
11) P&T Committee shall approve pharmacy educational programs for the hospital professional staff on matters related to drug use.

Meeting Schedule	The P&T Committee shall meet at least once every two months, or as determined by the Committee Chair

4. HOSPITAL ETHICS COMMITTEE (“HEC”)

Committee Mandate

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.

Membership

Chair	Head Department of Internal Medicine
Member	Representative from Department of Medical Oncology
Member	Representative from Department of Surgery
Member	Representative from Department of Paediatrics
Member	Representative from Department of Anaesthesia
Member	Representative from Department of Psychiatry
Member	Representative from Nursing Department
Member	Manager Quality Assurance
Member	Law Officer

Term	The Chair will serve for three years, while membership tenure will be for two years.
Secretary	A member will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Medical Director and Clinical Executive Committee (CEC). Details of Ethics-consult will be confidential and only a summary report will be presented.

Activities

1) The role of the HEC will be advisory
2) The HEC will provide two specific services: Ethics Consultative Service and Education
    a. *Ethics Consultative Service*
        i. 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.
        ii. 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.
        iii. An ethics consult can be triggered by anybody including the patient, family,

physician or staff.

iv. 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.

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

b. Education

i. Development and presentation of educational programs on ethical issues

ii. Continuing self-education of the committee members

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

3) The HEC will maintain confidentiality on the issues discussed.

4) *Future scope*: After the initial development of awareness amongst the hospital staff viz., scope of the committee can be enlarged to:

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

Meeting Schedule The HEC shall meet at least once every four months, or as determined by the Committee Chair

5. OPERATING ROOM COMMITTEE ("OR COMMITTEE")

Committee Mandate

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.

Membership

Chair	Representative from Department of Surgical Oncology
Member	Representative from Department of Surgery
Member	Representative from Department of Anesthesia
Member	Representative from Department of Emergency Medicine
Member	Manager CSSD
Member	Manager OR
Member	Manager Quality Assurance

Term	The Chair will serve for three years, while membership tenure will be for two years.
Secretary	Manager OR will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Medical Director, Clinical Executive Committee ("CEC") and Hospital Director.

Activities

1) The committee will review all surgical services utilization information. Reallocation of block time will occur on a quarterly basis.
2) The committee will ensure high quality and cost effectiveness in patient care, safety, OR personnel and efficient utilization of OR resources by:
    a. Establishing and monitoring quality standards, job descriptions, and credentials applicable in OR service areas.
    b. Recommending solutions to recurring and important problems brought to the committee's attention by members, OR user's or the Clinical Executive Committee (CEC). The problem may be in the forms of an incident report, patient complaint or as a result of tracking quality and efficiency indicators.

Meeting Schedule	The OR Committee shall meet at least once every three months, or as determined by the Committee Chair.

6. RADIATION PROTECTION COMMITTEE ("RPC")

Committee Mandate

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.

Membership

Chair	Representative from Department of Radiology
Member	Medical Physicist
Member	Manager Radiology
Member	Representative from Nursing Department
Member	Manager Quality Assurance

Term	The Chair will serve for three years, while membership tenure will be for two years.
Secretary	Medical Physicist will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Medical Director and Clinical Executive Committee ("CEC")

Activities

1) *Personnel Radiation Dose Monitoring*: Categorize and authorize active users of ionized radiation at the Institution and monitor their radiation doses

2) *Nuclear Licensing of the Institution*: The RPC manages the licensing of the Institution for the use of nuclear material. It is also responsible for procurement of the same.

3) *Use of Radiation and Radioactive Waste Disposal*: 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 RPC.

4) *External Links*: 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.

5) *Radiation Education*: Develop and implement radiation protection courses for various staff and Students.

6) Development of Radiation Protection guidelines for the Hospital

7) Radiation protection issues while implementing new services involving radiation or when research work is carried out using radioactivity.

8) Ethical issues associated with radiation related research such as radiation risks to personnel and volunteers, if any.

9) Any other radiation related issue that may arise in future as the hospital implements newer uses of radiation.

Meeting Schedule The RPC shall meet at least once every four months, or as determined by the Committee Chair.

7. NUTRITION SUPPORT COMMITTEE ("NSC")

Committee Mandate

1) Committee should develop and approve the policies regarding nutritional screening and develop methods/ tools of assessment for inpatients.
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.

Membership

Chair	Representative from Department of Gastroenterology
Member	Representative from Department of Medicine
Member	Representative from Department of Surgery
Member	Clinical Nutritionist
Member	Environmental & Hotel Services
Member	Representative from Nursing Department (In charge ICU)
Member	Manager Quality Assurance

Term	The Chair will serve for three years, while membership tenure will be for two years.
Secretary	Clinical Nutritionist will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Medical Director and Clinical Executive Committee ("CEC")

Activities

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

Meeting Schedule	The NSC shall meet at least once every two months, or as determined by the Committee Chair.

8. INTENSIVE CARE UNITS COMMITTEE ("ICUC")

Committee Mandate

1) The ICUC shall be responsible for the overall 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).
2) The committee shall identify and rectify long-standing problems related to ICUs.

Membership

Chair	Representative from Department of Anesthesia
Member	Representative from Department of Cardiology
Member	Representative from Department of Internal Medicine
Member	Representative from Department of Surgery
Member	Representative from Department of Pediatrics
Member	Representative from Department of Cardiothoracic Surgery
Member	Representative from Department of Hepato-Billiary Liver Transplant Surgery
Member	Representative from Department of Renal Transplant Surgery
Member	Representative from Nursing Department (In charge ICU)
Member	Representative from Blood Bank
Member	Manager Quality Assurance

Term	The Chair will serve for three years, while membership tenure will be for two years.
Secretary	Nurse In charge ICU will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Medical Director, Clinical Executive Committee ("CEC") and Hospital Director.

Activities

1) The ICUC shall be responsible for the professional practice of critical care medicine at the Institutional Hospital.
2) ICUC shall develop and implement policies and procedures pertaining to the utilization of Intensive Care Unit facilities.
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) 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
5) It shall act as a forum where issues relating to critically ill patients in various departments may be discussed and resolved

Meeting Schedule	The ICUC shall meet at least once every two months, or as determined by the Committee Chair.

9. MEDICAL RECORDS COMMITTEE ("MRC")

Committee Mandate

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)

Membership

Chair	Representative from Department of Medicine
Member	Representative from Department of Psychiatry
Member	Representative from Department of Anesthesia
Member	Representative from Department of Surgery
Member	Representative from Department of Pediatrics
Member	Representative from Department of Obstetrics/ Gynecology
Member	Representative from Department of Clinical Research
Member	Representative from Department of Pathology
Member	Representative from Nursing Department
Member	Manager Medical Records
Member	Manager Quality Assurance
Member	MIS Representative

Term	The Chair will serve for three years, while membership tenure will be for two years.
Secretary	Manager Medical Records will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Medical Director, Clinical Executive Committee ("CEC") and Hospital Director.

Activities

The MRC will be responsible for the following functions:

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.
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.
3) Advise the administration in matters pertaining to medical records.
4) Submit monthly minutes to the QCC, listing activities, and identified problems with recommendations, proposed solutions and alternative options.
5) Recommend various policies with respect to medical records as and when required.

Meeting Schedule The MRC shall meet at least once every four months, or as determined by the Committee Chair.

10. INFECTION CONTROL COMMITTEE ("ICC")

Committee Mandate

Infection Control Committee is a policy making body charged with:

1) Guiding the Infection Control Team (ICT) in carrying out its activities.
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.
3) Reviewing, revising and approving the Infection Control Manual every 3 years or whenever the need arise.
4) Enhancing the image of Infection Control in the organization, community and country at large.

Membership

Chair	Representative from Department of Infectious Diseases
Member	Representative from Department of Medical Oncology
Member	Representative from Department of Infectious Diseases
Member	Representative from Department of Surgery
Member	Representative from Department of Pediatrics
Member	Representative from Department of Obstetrics/ Gynecology
Member	Infection Control Nurse
Member	Manager CSSD
Member	Representative from Nursing Department
Member	Environmental & Hotel Services
Member	Manager Quality Assurance
Member	Microbiology Supervisor

Term	The Chair will serve for three years, while membership tenure will be for two years.
Secretary	IC Nurse will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Medical Director, Clinical Executive Committee (CEC) and Hospital Director.

Activities

1) Hold regular committee meetings and submit meeting minutes to Clinical Executive Committee ("CEC")
2) Submit quarterly Infection Control Report to Clinical Executive Committee ("CEC").
3) Guide infection control team in carrying out the following activities:
    a. Surveillance of Nosocomial Infections as defined by:

i. Nosocomial blood stream infection
ii. Nosocomial pneumonia
iii. Nosocomial Urinary Tract Infections
iv. Surgical wound infections
v. Multiple Antibiotics Resistant Organisms

b. Notifiable Infectious Disease care monitoring
c. Needle Stick Injury management and exposure to HBV, HCV and HIV contaminated blood/body fluids
d. Universal precautions, safety measures, and environmental control audits in all patient care and relevant areas e.g. Pharmacy, Laboratory etc.
e. 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
f. 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.
g. Actively participate in employee orientation and education program.
h. Developing, implementing and reinforcing Infection Control Procedures
i. Organize, conduct and support educational programs on Infection Control

Meeting Schedule The ICC shall meet at least once every two months, or as determined by the Committee Chair

11. BLOOD BANK COMMITTEE ("BBC")

Committee Mandate

1) The BBC shall be responsible for the overall monitoring and evaluation of quality assurance activities and programs related to blood and blood products usage in the hospital.
2) The committee shall identify and rectify long-standing and day-to-day problems related to blood and blood products usage.

Membership

Chair	Representative from Department of Haematology
Member	Representative from ICU
Member	Representative from Department of Medicine
Member	Representative from Department of Surgery
Member	Representative from Department of Pediatrics
Member	Representative from Department of Anaesthesia
Member	Representative from Department of Emergency Medicine
Member	Representative from Nursing Department
Member	Manager Laboratory & Blood Bank
Member	Manager Quality Assurance

Term	The Chair will serve for three years, while membership tenure will be for two years.
Secretary	Manager Laboratory & Blood Bank will act as Secretary to the Committee.
Reporting Relationship	The committee shall report to the Medical Director and Clinical Executive Committee (CEC).

Activities

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.
2) The BBC shall ensure the provision of quality services in terms of Blood and blood products to all the patients.
3) The committee shall be responsible to implement Maximum Surgical Blood order Schedule (MSBOS).
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.
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.

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

Meeting Schedule The BUC shall meet at least once every three months, or as determined by the Committee Chair.

12. HOSPITAL SAFETY COMMITTEE ("HSC")

Committee Mandate

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

Membership

Chair	Representative from Department of Orthopedic Surgery
Member	Manager OPD
Member	Manager Quality Assurance
Member	Manager EHS
Member	Representative E&M Department
Member	Manager Administration & Security
Member	Patient Relations Officer
Member	Representative from HR Department

Term	The Chair will serve for three years, while membership tenure will be for two years
Secretary	Manager Administration & Security will act as Secretary to the Committee
Reporting Relationship	The committee shall report to the Medical Director, Clinical Executive Committee (CEC) and the Hospital Director

Activities

1) The Committee will assist Quality Control Committee ("QCC") and user departments in preparing safety policies and procedures.
2) Participate in the orientation-training program for new employees and ongoing continued education program for onboard staff.
3) On need basis, assist QCC and user departments in preparing training material.
4) Participate in the multidisciplinary and theme inspections/audits of their area.
5) Review summary of safety and security related incidents, and design preventive measures for reductions of such occurrences.
6) Identify, and design remedial steps for unresolved workplace safety and security issues.
7) Design a Disaster Plan / Major Incident Plan.
8) Submit a quarterly report to the Quality Council, listing activities, and identified problems with recommendations, proposed solutions and alternative options.
9) Identify and recommend specialist training needs, with reference to safety, for employees.

Meeting Schedule	The Safety Committee shall meet at least once every two months, or as

determined by the Committee Chair.

13. CLINICAL AUDIT COMMITTEE ("CAC")

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".

Committee Mandate

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

Membership

Chair	Representative from Department of Surgery/ Medicine
Member	Representative from Department of Pathology
Member	Representative from Department of Paediatrics
Member	Representative from Department of Surgery/Medicine
Member	Manager Quality Assurance
Member	Quality Assurance Officer

Term	The Chair will serve for three years, while membership tenure will be for two years
Secretary	Quality Assurance Officer will act as Secretary to the Committee
Reporting Relationship	The committee shall report to the Medical Director and Clinical Executive Committee (CEC)

Activities

1) Develop & implement a systematic corporate approach to clinical audit.
2) CAC shall be responsible for planning and scheduling the clinical audit plan.
3) CAC shall be responsible for the selection & allocation of topics for audit to the relevant Consultants.
4) Encourage a multidisciplinary approach to clinical audit; that tracks the patient's journey delivering evidence based care.
5) Ensure clinical audit has a high profile and findings/best practices are shared among the medical staff.
6) CAC shall analyze and review the clinical audit reports.

Meeting Schedule	The CAC shall meet at least once every three months, or as determined by the Committee Chair.

XIX. APPENDIX 8: FACULTY SELECTION & PROMOTION

1. SELECTION (RECRUITMENT) PROCEDURES

(1) The Selection procedures will be as noted in Regulations VII.

(2) Upon receipt of applications for a post, the secretary (HR officer) of the Faculty Selection Committee will prepare an initial merit list based on the items below, except for the interview, which will be scrutinized by the selection committee.

(3) The list of candidates of various specialties will be sent to the Head of the concerned Department (HOD), who will review this list with his/her faculty and shortlist the candidates to be invited for the interview. In the event of three (3) or fewer eligible applicants, all applicants will be shortlisted.

(4) Letters will be sent to the referees of the first six (6) candidates, based on the merit list, or to referees of all the shortlisted candidates if less than six (6) are shortlisted. A maximum of 15 days will be allowed for receipt of reference letters from the time of contact (referees can be contacted by letter/phone or email). Interviews cannot proceed without the availability of the referee letters. In the event that the reference letters for a shortlisted candidate are not received three (3) days prior to the interviews, the next candidate on the initial merit list for whom reference letters are available, may be invited for interview if the short list would be left with fewer than three (3) candidates.

(5) A negative reference letter will exclude a candidate from the shortlist; however, the faculty selection committee may, after investigation, choose to leave the candidate on the shortlist, but must document their reason for doing so.

(6) At the same time as reference letters are requested, interviews will be scheduled allowing sufficient time for the candidates to conveniently attend, but not exceeding six weeks.

(7) The interviews will be by a faculty selection committee consisting of the HOD of the concerned department and at least two thirds of the departmental/divisional faculty members (consisting of a representative sample including assistant, associate and full professors) and one member of a completely separate department (who can be an assistant, associate or full professor, but ideally not HOD) nominated by the Dean. In addition, where necessary, an internal or external expert approved by the Dean may be included in the selection committee.

(8) Eligibility of the candidates shall be determined in accordance with the advertisement of the post. For this purpose, for all candidates the qualifications and experience etc. as on the closing date fixed/ relevant for all candidates will be considered. It is to be noted that:

   (a) Canvassing in any form will disqualify the candidate.

   (b) The candidate may be disqualified and/or excluded from interview and/or be proceeded against legally/ debarred from employment if he / she:

      (i) Knowingly furnishes any particular which is false;

      (ii) Suppresses material information:

(iii) Attempts to influence the Members of the Board, the officers and officials of the faculty selection committee, Advisors and Departmental Representative called to assist the selection panel in the interview;

(iv) Attempts to obtain support for his / her candidature by improper means;

(v) Submits forged certificates;

(vi) Tampers with the entries in his / her academic certificates.

2. ELIGIBILITY [RECRUITMENT] CRITERIA FOR SELECTION OF SENIOR REGISTRAR/ ASSISTANT PROFESSOR

Meets all PMC requirements (as amended by PMC from time to time) pertaining to qualification, experience and publications for the position.

(1) ACADEMIC QUALIFICATIONS (maximum 15 marks)

In case of a newly introduced specialty/subspecialty, first preference will be given to candidate with qualification in relevant specialty. However, if first preference is not available, candidate with FCPS or equivalent qualification in general medicine/general surgery with three years practical or teaching experience in relevant specialty /discipline in a recognized institution/reputed hospital may be considered

(a) Only the qualifications and experience possessed on the closing date of the application shall be taken into consideration.

(b) A candidate who has been declared to have passed a particular Degree / Diploma examination may be considered provisionally on the basis of provisional certificates signed by the Controller of Examination provided that the proper degree/ PMC certificate will be provided to the faculty selection committee on or prior to the interview day.

(c) The eligibility of a candidate claiming to be in possession of equivalent Qualifications shall be decided by the Faculty Selection Committee on the merits of each case and/or on the production of a PMC certificate.

(d) MARKS: Marks may be awarded if the candidate possesses in addition to the major requisite qualification for his/her specialty an additional FCPS, PhD or equivalent qualification @ 10 marks/qualification. Masters, Diploma (1 year minimum) or equivalent in a field/subject relevant to the major requisite postgraduate qualification @05 marks/qualification

(2) EXPERIENCE (maximum 10 marks)

When experience is laid down as a part of qualification the following principles shall be followed in determining the experience:

(a) If not specifically provided otherwise, prescribed experience means the experience gained in a regular fulltime paid job acquired after obtaining the prescribed qualification.

(b) Experience gained during appointment on ad-hoc or contract basis or in officiating capacity shall be counted towards eligibility.

(c) Period of training undergone by a candidate for becoming eligible for the award of actual degree/certificate shall not be counted.

(d) Period of training undergone by a candidate after postgraduation for becoming eligible for the Post shall not be counted.

(e) Teaching Experience must be in a recognized public or private Medical Teaching Institution.

MARKS: Marks may be given for experience gained after the minimum experience required for the post as per PMC/MTI regulation, as follows:

Demonstrator, Senior Demonstrator, Specialist Registrar, Senior Registrar, Assistant Professor or Consultant in a specialty in a reputable institution in Pakistan or a developed/foreign country in the relevant field AFTER major requisite postgraduate qualification and experience:

Assistant Professor/ Consultant @03 marks/year

Senior Demonstrator/ Senior Registrar @02 marks/year

Demonstrator/ Specialist Registrar/ Medical Officer @01 marks/year

(3) RESEARCH (maximum 20 marks)

Research Publications

- Marks will be awarded as per PMC/HEC criteria for research papers – Max 20 marks
- Marks will be assigned as follows:

(a)	Publications in HEC recognized journals	Up to 5 marks each
(b)	"W" category journals	5 marks each
(c)	'X' or 'Y' category journals	4 marks each
(d)	No marks for paper in unrecognized journals	0 marks

(4) EXTRA TRAINING/CERTIFICATION (maximum 5 marks)

Extra training/certification of at least six months duration in a related specialty will be given additional marks, @ 02 marks/certification.

(5) REFERENCE LETTERS (maximum 05 marks)

A maximum of 3 referee letters may be considered. Each letter will be marked by each selection committee member on a grading of 0 to 2, provided that a poor reference will require further investigation by the selection committee and the final findings may result in exclusion of the candidate from consideration.

(6) INTERVIEW (maximum 45 marks):

		Max Marks
i	Knowledge of concerned specialty/subject	15
ii	Research related knowledge	10
iii	Communication skills (articulate, confident)	10
iv	Knowledge of medical ethics	5
v	Leadership skills, clinical governance/audit	5
	Total Marks	**45**

Passing marks for interview will be 25 marks. If the marks given by any member of the faculty selection committee fall outside the average marks of all the members by more than 25%, the reviewer may reconsider his/her marks, or the reviewer’s marks will be excluded from the final calculation.

(7) SUMMARY OF MARKS

	Description	**Max Marks**
1	Academic Qualifications	15
2	Additional Experience	10
3	Research	20
4	Extra Training & Certification	05
5	References	05
6	Interview	45
	Total Marks	**100**

3. ELIGIBILITY CRITERIA FOR SELECTION [RECRUITMENT] OF ASSOCIATE PROFESSOR/ PROFESSOR

(1) REQUIRED QUALIFICATIONS:

Meets all PMC requirements (as amended by PMC from time to time) pertaining to qualification, experience and publications for the position.

(2) PRE-INTERVIEW MARKING SHEET [maximum 60 marks]

	Item Description	**Max Marks**
1	*Additional qualifications* in current post [subspecialty certification/training]	10
2	*Administrative activities* [Member of an academic or administrative committee of the institution.]	10
3	*Scholarship*:	
(a)	*Published papers* [Published papers, a total of 10 papers (out of which 4 must be in the last five years) for Associate Professor, and 15 papers (out of which 5 must be in the last five years) required for the post of Professor as per PMC/HEC criteria.]*	20
(b)	*Presentations* at international and national medical meetings	5
4	Continuing involvement in scholarship and *Research* (grants, abstracts}	4
5	*References*: A maximum of 3 referee letters may be considered. Each letter will be marked by each selection committee member on a grading of 0 to 2, provided that a poor reference will require further investigation by the selection committee and the final findings may result in exclusion of the candidate from consideration.	6
6	*Medical Education*: excellence in teaching, [student evaluations, student performance, development of teaching programs, etc.] for basic scientists documented supervision of at least 6 successful, M.Phil or higher degree candidates.	5
	Total Marks	**60**

(3) INTERVIEW (maximum 40 marks):

	Item Description	**Max Marks**
i	Additional qualifications in current post [subspecialty certification/training]	10
ii	Knowledge of concerned specialty/subject	5
iii	Quality of current practice [Institution/facilities]	1
iv	National/international peer recognition [visiting = 5 marks professorships, invited]	5

iv	Research related knowledge	5
v	Communication skills (articulate, confidence)	5
vi	Knowledge of medical ethics	5
vii	Leadership skills, clinical governance/audit	5
	Total Marks	**40**

A minimum of 25 marks are necessary in the interview for selection.

(4) RESEARCH* (maximum 20 marks)

Research Publications

For assigning marks for publications the following considerations will apply:

- A total of 10 papers (out of which 4 must be in the last five years) for Associate Professor, and 15 papers (out of which 5 must be in the last five years) are required for the post of Professor as per PMC/HEC criteria.
- Marks will be awarded as per PMC/HEC criteria for research papers
- For assessment purpose in Professor category, 15 papers required will carry weightage of 75% marks as per distribution given below.

(a)	'W' category journals	5 marks
(b)	'X' or 'Y' category journals	4 marks
(c)	No marks for paper in an unrecognized journal	0 marks

For assessment purpose in Associate Professor category, 10 papers required will carry weightage of 50% marks as per distribution given below.

(a)	'W' category journals	5 marks
(b)	'X' or 'Y' category journals	4 marks
(c)	No marks for paper in an unrecognized journal	0 marks

(5) FINAL DECISION/RECOMMENDATION.

(a) Marks distribution for Selection (recruitment) of faculty as associate or full professor: Total marks: 100 [minimum 60 marks necessary for selection, including at least 25 marks in interview]

(b) When all shortlisted candidates have been interviewed, the secretary of the Faculty Selection Committee, shall prepare a merit list based on the aggregate marks obtained on the evaluation sheets and submit to the Chair of the Faculty Selection Committee.

(c) The Faculty Selection Committee will review the list in conference and come to a final decision on the grading of the candidates. The rationale for this grading will be written by the Chair and approved and signed by members of the Faculty Selection Committee.

(d) The selected candidate will be recommended to the Dean for appointment.

(e) When two or more than two candidates have secured equal marks in aggregate, the candidate who has secured higher marks in the interview shall be given preference. In case the marks in aggregate and also the marks in the interview are the same, marks obtained in the Research Publication shall be the deciding factor.

(6) REPRESENTATION

Representation should be addressed to the Academic Council, which shall decide the case on merit alone and will advise the Dean who will be the final authority.

N.B.

ALL MEMBERS OF THE FACULTY SELECTION COMMITTEE ARE REQUIRED TO WRITE THEIR RATIONALE FOR AWARDING MARKS FOR EACH ITEM.

MEMBERS OF THE FACULTY SELECTION COMMITTEE MUST RECUSE THEMSELVES FROM THE COMMITTEE IF THEY PERCEIVE A CONFLICT OF INTEREST AS DEFINED IN THE SZPGMI CONFLICT OF INTEREST REGULATION (Appendix 6, Section 3(19)).

4. PROMOTION PROCEDURES

The promotion procedure will be as noted in Regulations VIII. Promotion Criteria/Marks distribution for Promotion of Faculty to Associate Professors or Full Professor in SZPGMI are as follows.

(1) REQUIRED QUALIFICATIONS FOR REGULAR PROMOTIONS TO ASSOCIATE & FULL PROFESSOR

(a) Meets all PMC requirements (as amended by PMC from time to time) pertaining to qualification, experience and publications for the position.

(b) Certified supervisor of CPSP or University approved supervisor status for M.Phil, MS, MD or PhD degree,

	Item Description		Max Marks
1)	**Research Publications**		**30**
	Marks will be awarded as per PMC/HEC criteria for research papers		
	For assessment purpose in Professor category, 15 papers required		
	Papers will carry weightage of 75% marks as per distribution given below:		
(a)	'W' category journals	5 marks	
(b)	'X' or 'Y' category journals	4 marks	
(c)	No marks for paper in an unrecognized journal	0 marks	
	For assessment purpose in Associate Professor category, 10 papers required		
	Papers will carry weightage of 50% marks as per distribution given below		
(a)	'W' category journals	5 marks	
(b)	'X' or 'Y' category journals	4 marks	
(c)	No marks for paper in an unrecognized journal		
2)	**Excellent Clinician**		**25**
	Excellent clinician (*see definition below*) OR Documented supervision of 6 successful M.Phil or higher degree candidates		
	Excellent clinician to be decided by DPC & verified by IPC and Dean. Excellence as clinician is assessed on the following basis:		
(a)	Written evaluations of national clinical stature by at least two (2) colleagues and two (2) referees from outside institutions	max 10 marks	
(b)	Documented attendance and supervision of regular morbidity and mortality reports and clinical audit sessions at least on two (2) monthly bases	max 5 marks	
(c)	Documented contribution to health system improvement	max 5 marks	
(d)	Documented development of new clinical skills and expertise resulting in additional clinical privileges in the current post	max 10 marks	
(e)	Obtaining additional recognized degree/diploma while in the post	max 10 marks	
3)	**Excellent Teacher**		**15**
	Excellent teacher is defined as having the following qualities:		
(a)	A minimum of 05 presentations per year in the current post on clinical and educational topics verified by different means (CPCs, Multi Disciplinary meetings, workshops, conferences, CMEs)	max 10 marks	
(b)	Written evaluations from trainees and students	max 10 marks	

4)	**CME Credit Hours [0.1 marks / credit hour]**		**5**
5)	**Scholarly Activities**		**10**
	Presentations at National or International Conferences (with paper/ abstract presentation)	1 mark for each	
	Workshop/symposia organizer	1 mark for each	
	Editor of Nationally recognized Journal	2 marks for each	
	Review article, meta analysis, editorial in a recognized journal	0.5 marks each	
	Journal article review	0.5 marks each	
6)	**Administrative Activities**		**10**
	Administrative Activities are: Member (4 marks)/ Chair (6 marks) of different Hospital or Academic administrative committees (including inquiry committees)		
7)	**Personal Qualities and Reputation**		**-20 to +5**
	Personal Qualities and Reputation: • No legal cases relevant to faculty duties with adverse outcomes to the applicant (-5 marks for each such outcome) • Good interpersonal relations with peers, students, trainees • Absence of any adverse findings/actions regarding any faculty activities by supervisors (-5 marks for each such finding)		
	Total Marks		**60**

Total marks: 100 [60 marks necessary for promotion and 70% & above for accelerated promotion after 5th year.

N.B.

1. ALL MEMBERS OF THE INSTITUTIONAL PROMOTION COMMITTEE (“IPC”) ARE REQUIRED TO WRITE THEIR RATIONALE FOR AWARDING MARKS FOR EACH ITEM

2. IF THE MARKS GIVEN BY ANY MEMBER OF THE INSTITUTIONAL PROMOTION COMMITTEE FOR ANY ITEM FALL OUTSIDE THE AVERAGE MARKS OF ALL THE MEMBERS FOR THAT ITEM BY MORE THAN 25%, THE REVIEWER MAY RECONSIDER HIS/HER MARKS, OR THE REVIEWER’S MARKS WILL BE EXCLUDED FROM THE FINAL CALCULATION.

3. IF THE CANDIDATE HAS WORKED IN ANOTHER REPUTABLE INSTITUTION AS A FACULTY MEMBER, THAT TIME SHOULD BE CONSIDERED, AS WELL THE PAPERS PUBLISHED DURING THAT POSTING.

XX. APPENDIX 9: DISCIPLINARY POLICY

1. INTRODUCTION

(1) The SZPGMI Disciplinary Policy as hereunder.

(2) Provided that the present Policy will not affect or change the Board approved Medical Malpractice Enquiry procedure (to be notified separately).

(3) This disciplinary policy shall come into force at once and will be applicable to all employees of SZPGMI.

(4) Dean SZPGMI will be the competent authority for all disciplinary proceedings. An Inquiry shall be undertaken by an Authorized Officer (Hospital Director, Medical Director, Nursing Director, or by an Officer appointed by the competent authority).

2. GROUNDS FOR PENALTY

(1) An employee who:

(a) Is inefficient or has ceased to be efficient; or

(b) Is guilty of misconduct; or

(c) Is corrupt, or may reasonably be considered corrupt; or

(d) Is engaged, or is reasonably suspected of being engaged in subversive activities or is guilty of disclosure of official secrets to any unauthorized person, and his retention in service is, therefore, prejudice to national security;

(2) The authority may impose on him one or more penalties, shall be liable to be proceeded against as hereinafter provided and one or more of the penalties hereinafter mentioned may be imposed upon him.

3. DEFINITION OF MISCONDUCT

(1) Misconduct means conduct prejudicial to good order or working discipline or contrary to SZPGMI regulations, employee code of conduct under the FMTI Act (as amended time to time).

(2) **Simple Misconduct** includes, but is not limited to:

(a) Persistent poor performance of assigned duties

(b) Unlawful gathering.

(c) Insubordination and breach of lawful order.

(d) Unauthorized absenteeism.

(3) **Gross Misconduct** includes, but is not limited to:

(a) Unauthorized absenteeism of more than 07 days.

(b) Dishonesty and theft or financial misappropriation

(c) Threatening or causing physical harm to patients, staff, or visitors in SZPGMI

(d) Harassment (verbal, physical or sexual) – see Harassment Policy

(e) Violation of the FMTI Act, regulations, policies including health &; safety and security regulations and procedures.

(f) Violation of law.

(g) Engagement in subversive activities on SZPGMI premises.

(h) Misappropriation, corruption, or misuse of SZPGMI funds or property.

(i) Unauthorized disclosure of internal correspondence or confidential documents, decisions, procedures or actions of SZPGMI.

(j) Any other act which the competent authority deems serious in nature.

4. PENALTIES

The following are the minor and major penalties, namely:

5. MINOR PENALTIES

(1) Censure;

(2) Withholding, for a specific period, promotion or increment otherwise than for unfitness for promotion or financial advancement in accordance with the Regulations or orders pertaining to the service or post;

(3) Stoppage, for a specific period, at an efficiency bar in the time scale otherwise than for unfitness to cross such bar; and

(4) Recovery from pay of any pecuniary loss caused to the Institute or Government by negligence or breach of orders

6. MAJOR PENALTIES

(1) Reduction to a lower post of pay scale, or to a lower stage in a pay scale;

(2) Compulsory retirement;

(3) Removal from service; and

(4) Dismissal from service

(a) Removal from service does not but dismissal from service does disqualify for future employment;

(b) In these Regulations, removal or dismissal from service does not include the discharge of a person:

(i) Appointed on probation, during the period of probation, or in accordance with the probation of probation, or in accordance with the probation or training rules applicable to him; or

(ii) Appointed, otherwise than under a contract, to hold a temporary appointment, on an expiration of the period of appointment; or

(iii) Engaged under a contract in accordance with the terms of the contract.

7. INQUIRY PROCEDURE

The following procedure shall be observed when an employee is proceeded against under these Regulations:

(1) In case where an employee is accused of subversion, corruption or misconduct, the authorized officer may require him to proceed on leave or, with the approval of the authority, suspend him, provided that any continuation of such leave or suspension shall require approval of the authority after every three months;

(2) The authorized officer shall decide whether in the light of facts of the case or the interests of justice an inquiry should be conducted through an Inquiry officer or Inquiry committee, if he so decides, the procedure indicated in Appendix 9, Section 7(4) shall apply;

(3) If the authorized officer decides that it is not necessary to have an inquiry conducted through an Inquiry officer or Inquiry committee, he shall:

(a) By order in writing, inform the accused of the action proposed to be taken in regards to him under the grounds of the action; and

(b) Give him a reasonable opportunity of showing cause against that action;

(c) Provided that no such opportunity shall be given where the authority is satisfied that in the interest of the security of Pakistan or any part thereof it is not expedient to give such opportunity

(4) On receipt of the report of the Inquiry officer or Inquiry Committee or where no such officer or committee is appointed, on receipt of the explanation of the accused, if any, the authorized officer shall determine whether the charge has been proven. If it is proposed to impose a minor penalty, he shall pass orders accordingly. If it is proposed to impose a major penalty, he shall forward the case to the authority along with the charge and statement of allegation served on the accused, the

explanation of the accused, the findings of the Inquiry officer, or Inquiry committee, if appointed, and his own recommendations regarding the penalty to be imposed. The authority shall pass such orders as it may consider proper.

8. PROCEDURE TO BE OBSERVED BY THE INQUIRY OFFICER AND INQUIRY COMMITTEE

(1) Where an inquiry officer or Inquiry Committee is appointed, the authorized officer shall;

(a) Frame a charge and communicate it to the accused together with statement of the allegations explaining the charge and of any other relevant circumstances which are proposed to be taken into consideration; and

(b) Require the accused within a reasonable time which shall not be less than seven days or more than fourteen days from the day of the charge has been communicated to him, to put in a written defence and to state at the same time whether he desires to be heard in person;

(2) The Inquiry Officer or Inquiry Committee as the case may be, shall inquire into the charge and may examine such oral or documentary evidence in support of the charge or in 'defence' or the accused as may be considered necessary and the accused shall be entitled to cross examine the witness against him;

(3) The Inquiry Officer or Inquiry Committee, as the case may be, shall hear the case for day to day and no adjournment with reasons therefore, shall be reported forthwith to the authorized officer. Normally, adjournment shall be for more than a week.

(4) Where the Inquiry Officer or the Inquiry Committee, as the case may be, is satisfied wthat the accused is hampering, or attempting to hamper, the progress of the inquiry he or it shall administer a warning, he or it shall record finding to that effect and proceed to complete the inquiry in such manner as he or it thinks best suited to do substantial justice.

(5) The Inquiry Officer or the Inquiry Committee, as the case may be, shall within ten days of the conclusion of the proceedings of such longer period as may be allowed by the authorized officer, submit his or its findings and the grounds thereof to the authorized officer.

9. POWERS OF INQUIRY OFFICER AND INQUIRY COMMITTEE

For the purpose of an inquiry under these regulations, the Inquiry Officer and the Inquiry Committee shall have the powers of a civil court trying a suit under the code of civil procedure, 1908 (Act Y of 1908) in respect of the following matters, namely:

(1) Summoning and enforcing the attendance of any person and examining him on oath;

(2) Requiring the discovery and production of documents;

(3) Issuing commissions for the examination of witnesses or document

10. APPENDIX 9, SECTION 7 NOT TO APPLY IN CERTAIN CASES

Nothing in Appendix 9, Section 7 shall apply to a case:

(1) Where the accused is dismissed or removed from service or reduced in rank, on the ground of conduct which has led to a sentence of line or of imprisonment; or

(2) Where the authority competent to dismiss or remove a person from service, or to reduce a person in rank, is satisfied that, for reasons to be recorded in writing by that authority, it is not reasonably practicable to give the accused on opportunity or showing cause.

11. ACTION IN RESPECT OF THE EMPLOYEE REQUIRED TO PROCEED ON LEAVE

If an employee proceeding on leave in pursuance of an order under clause of Appendix 9, Section 7, is not dismissed, removed on service, reduced in rank or compulsorily retired, he shall be required to rejoin duty and the period of such leave shall be treated as duty on fully pay.

12. PROCEDURE OF INQUIRY AGAINST OFFICER LENT TO PROVINCIAL GOVERNMENT ETC.

(1) Where the services of an employee are lent to the Federal Government or Provincial Government or to a local or other authority, in this regulation referred to, as the borrowing authority shall have the powers of the authority for the purpose of placing him under suspension or requiring him to proceed on leave and of initiating proceedings against him under these regulations; provided that the borrowing authority shall forthwith inform the authority which has lent his services, of the circumstances leading to the order of his suspension or the commencement of the proceedings, as the case may be.

(2) If in the light of the findings in the proceedings taken against the employee in terms of sub-regulation (1) the borrowing authority is of opinion that only penalty should be imposed on him, it shall transmit to the lending authority the record of the proceedings and thereupon the lending authority shall take action as prescribed in these regulations.

13. APPEARANCE OF COUNSEL

No party to any proceedings under these regulations before the authority, the authorized officer, and inquiry officer or any inquiry committee shall be represented by an advocate.

14. APPEAL

(1) The employee may appeal the decision of the competent authority, within thirty days of issuance of the decision to the Board, whose decision in the matter will be final as regards the FMTI. However, the individual may appeal the decision of the Board to the appropriate higher forum within 30 days.