

The role of the medical committee in hospital's clinical governance in Jambi Province

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The role of the medical committee in hospital's clinical governance in Jambi Province

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Abstrak

Latar Belakang: Tata kelola klinis bertujuan untuk memastikan bahwa layanan kesehatan berjalan sesuai dengan standar keamanan yang tinggi dan kualitas berkelanjutan. Komite Medik bertanggung jawab untuk pelaksanaan tata kelola klinis yang baik di rumah sakit. Penelitian ini bertujuan untuk mengetahui peran Komite Medik dalam tata kelola klinis rumah sakit di era Jaminan Kesehatan Nasional (JKN) pada RS Umum Daerah (RSUD) di Provinsi Jambi.

Metode: Desain penelitian bersifat kualitatif. Pengumpulan data dari Agustus hingga Desember 2016 di tiga RSUD kelas C di Provinsi Jambi dan mencakup 23 informan yang diambil melalui wawancara mendalam dan Focus Group Discussion.

Hasil: Hasil penelitian menunjukkan bahwa Komite Medik belum berperan optimal dalam proses kredensialing, pemeliharaan mutu profesi dan penjagaan disiplin/etika profesi. Tugas dan fungsi kredensialing di beberapa rumah sakit belum berjalan sebagaimana mestinya (karena digunakan untuk persyaratan penerimaan dokter baru, tetapi tidak untuk menyaring kompetensi dokter), terkesan formalitas, serta sulit dilakukan karena belum memiliki Mitra Bestari. Kebijakan Jaminan Kesehatan Nasional memberi pengaruh baik terhadap peran komite medik dalam tata kelola klinis RS, karena terdapat beberapa regulasi atau peraturan pelaksana tentang JKN yang terintegrasi dengan peran komite medik, khususnya pada aspek kendali mutu kendali biaya.

Kesimpulan: Dapat disimpulkan Komite Medik secara umum belum berperan optimal dalam tata kelola klinis pada RSUD Kelas C di Provinsi Jambi. Oleh karena itu, rumah sakit perlu meningkatkan kompetensi, etika dan disiplin profesi medik, serta penyempurnaan regulasi terpadu terkait tata kelola klinis di rumah sakit. (*Health Science Journal of Indonesia 2018;9(2):100-6*)

Kata kunci: komite medik, tata kelola klinis, RS, Jaminan Kesehatan Nasional.

Abstract

Background: Clinical governance aims to ensure that health services run according to high safety standards and ongoing quality. The medical committee is responsible for the implementation of good clinical governance of the hospital. This study aims to analyze the role of the medical committee in the clinical governance of hospitals in the era of National Health Insurance (JKN).

Methods: The research design is qualitative. Data collection spans from August to December 2016 in three hospitals in Jambi Province and includes 23 informants who were observed throughout in-depth interviews and focus group discussions.

Results: The results show that the medical committee has not played an optimal role in the process of credentialing, maintaining professional quality, and guarding the discipline/professional ethics of the hospital. The duties and functions of credentials in some hospitals are not working properly (because used to apply to new doctor admission requirements, but not as to screen the competence of doctors), seem excessively formal and difficult to implement because they do not have Mitra Bestari yet. JKN policy has a good influence on the role of the medical committee in the clinical governance of the hospital, as there are several regulations that are integrated with the role of the medical committee, especially in the areas of quality control and cost control.

Conclusion: It can be concluded that the medical committee in general has not played an optimal role in the clinical governance of hospitals in Jambi Province. Therefore, it is necessary to improve the competence, ethics, and discipline of the medical profession in addition to integrating regulations related to clinical governance in hospitals. (*Health Science Journal of Indonesia 2018;9(2):100-6*)

Keywords : Medical committee, clinical governance

The concept of clinical governance is a new approach aimed at ensuring the continuity of health services with high safety standards and continuous quality. Currently, there are seven key elements, more popularly known as the Seven Pillars of Clinical Governance. They include: patient and public involvement, clinical audit, risk management, clinical effectiveness, staffing and staff management, education and training, and use of information.¹

Clinical rules of governance applying to hospitals in Indonesia are contained in Indonesian Law 44/2009. Article 36 explains that good clinical governance results from the application of clinical management functions that include clinical leadership, clinical audit, clinical data, evidence-based clinical risk, performance improvement, grievance management, monitoring mechanisms of service delivery, professional development, and hospital accreditation. Furthermore, article 46 explains that the hospital is responsible for all the harm done by the health personnel in the hospital.²

Therefore, the hospital is obliged to create internal hospital regulations such as hospital by-laws and medical staff by-laws. The medical committee is responsible for the implementation of good clinical governance in hospitals through clinical privilege delineation, credentialing mechanisms, and clinical appointment. Minister of Health regulation number 755 of 2011 addresses the organization of the medical committee at the hospital and confirms that the medical committee is an instrument for hospitals to apply to clinical practice so that medical staff professionalism is maintained through credential mechanisms, professional custody maintenance, and maintenance of ethics and professional medical discipline.³

The National Health Insurance Policy (*JKN*) brings a major change to the medical service system in that the consideration of hospitals as Advanced Referral Health Facilities has implications for the role of the medical committee. The medical committee determines the success of the *JKN* program in terms of maintaining the quality of the medical profession, cost control, and fraud prevention in hospital services. The system of payment of fees using the disease-based service package group, currently known as *INA-CBGs*,⁴ greatly affects the hospital (abbreviated as *RS* = rumah sakit) service system.

Based on study in one of the hospitals in Jambi City found that the culture of patient safety is still not good and also found some mistakes of the officer in the service was caused by the human factor and

system failure. There are even hospitals that have not implemented practices that will improve patient safety in surgery.^{5,6}

Therefore, the purpose of this research is to determine the role of the medical committee in clinical governance of *RS* under the *JKN*, especially in General Hospital (*RSUD*) of Jambi Province and to assess the extent to which the medical committee has played a role in accordance with the principles of medical professionalism in the clinical governance of hospitals under National Health Insurance.

METHODS

A qualitative study was done between August to December 2016 in three district/city hospitals in Jambi Province and three institutions in Jakarta, namely Indonesian Medical Council (*KKI*), Board of Indonesian Doctors Association (*PB-IDI*), and Indonesian Hospital Association (*PERSI*). The selected hospitals are Class C with different accreditation status, and belong to Regency/City government representing East, West, and Central Jambi region. They include: *RSUD* Abdul Manap (*RSUD AM*) of Jambi City, *RSUD* H.Abdul Madjid Batoe (*RSUD HA*) Kab. Muara Bulian, *RSUD* Prof.DR.HM.Chatib Quzwain (*RSUD CQ*) Kab. Sarolangun.

Data were collected through in-depth interviews, focus group discussions (FGDs), participant observation, document review, and information from related institutions. There were 23 people participated as interviewees, such as: Head of *KKI*, Head of *PB-IDI*, Head of Clinical management compartment *PERSI*, and Director, Head of Medical Services, Head of Medical committee, sub-committees chairmen in all hospitals studied.

Role of the medical committee consist of credentialing (entering the profession), maintaining the profession, and maintaining the professional ethics and discipline (expelling from the profession), and were derived from several theories.^{7, 8, 9, 10, 11}

Techniques used in this research to understanding the role of the medical committee in clinical governance at hospital. The role is described mainly in the aspects that apply to the credentialing of medical staff, the maintenance of professional quality, and the maintenance of ethics and professional discipline. The credentials and re-credentialing mechanisms in hospitals are the responsibility of the medical committee and are undertaken by the credential

subcommittee. The credential process is carried out in a spirit of openness, fairness, and objectivity, and in accordance with procedures and proper documentation.

The validity of the research data was ensured using the source triangulation technique, method triangulation,

and data triangulation.¹² Data analysis was performed using content analysis and the resulting aggregation is clear and comprehensive.

Ethical Clearance were not conducted, but only required there inform concern on each informant interviewed.

Table 1. Description of Credential Process in 3 Hospitals in Jambi Province

Aspect	Credential Process in 3 Hospitals in Jambi Province		
	RSUD AM	RSUD HA	RSUD CQ
The process of credentials of medical staff	It's been routinely running for all the new medical staff, but it has not gone well	Rarely done. However, documents about clinical privilege and clinical appointment remain complete for the benefit of accreditation	It's been running even though not all the stages are done well. Recredentialing process has never been done.
The authority of the Medical Committee in the recommendation of medical staff.	Only formality, as most of the new medical staff are "depositions" from the ruling party, so they remain accepted as medical staff without waiting for the results of credentials	The duties and functions of Medical Committee are not running properly. Credential process are difficult because they do not have Mitra Bestari, the peer group consisting of specialist doctor	It's done for newly admitted general practitioners, as well as assisting hospital managers in terms of licensing and registration of medical staff.
Subcommittee of Credentials function	Just for administrative requirements	Credentials for GPs are not done. The division of task for general practitioners, depending on the agreement, in the Medical Committee forum with the hospital management.	The general practitioner is credited by a specialist, while the specialist doctor by the collegium (bestari partner).
The process of credentialing to the Specialist Doctor	Not too questionable because it is clear competence from collegium.	Never questioned because the hospital itself is still short of Specialist Doctors.	Never questioned.
Clinical Privilege Assessment	Not running as per proper rules.	Not yet clear, but there is a clinical privilege document containing details of clinical authority for each medical staff.	Already running.
The process of licensing and registration of medical staff	It's been going well.	It's been going well.	It's been going well.

RESULTS

Table 1 explains that at all RSUD research sites, credential activities have not run optimally. Most are used to apply to new doctor admission requirements, but not as a means to screen the competence of doctors. However, the licensing and registration process of medical staff has been running maximally due to binding legislation such as the Medical Practice Law and the credentials of BPJS. The role of the medical committee in terms of licensing and registration is to assist hospital management in the coaching of medical staff. Medical Practice License (*SIP*) doctors in health facilities are also an absolute requirement among medical staff in order to perform *JKN* health services, and this relates to the validity of the claim.

This process consists of medical audits, Continuing Medical Education Program (*P2KB*), proctoring, service standards, medical resumes and medical verification, cost control. and the accreditation quality of Hospital Program. Medical audits are conducted to ensure good clinical management in hospitals. Medical audits are not used to look for the presence or absence of medical staff errors, as they were in one case. If there are reports of events with alleged negligence of medical staff, a professional disciplinary mechanism is used rather than a medical audit.

Medical audit activities have been performed in all three research location hospitals but are not yet optimal (Table 1). Audits have only been conducted when there is a case of death or if there is a complaint but have not been done as a routine activity (Table 1).

For *P2KB*, the Sub-Committee of the Professional Quality Committee is entitled to recommend continuing education for medical staff. *P2KB* activities at all hospital research locations have been running but are not yet optimal (Table 1). In general, *P2KB* takes the form of internal and external scientific meetings. Internal meetings are often conducted with an internship doctor who sometimes works closely with the local Branch IDI while external scientific meetings are usually conducted by medical staff in person and are self-financing. In RSUD CQ, *P2KB* activities are supported by directors with substantial funds. Each specialist is paid for two meetings per year, whereas general practitioners are paid for once a year and prioritized for competency trainings such as ATLS, ACLS, Neonatal Resuscitation and so on (Table 1).

For proctoring duties, the Professional Quality Subcommittee facilitates the mentoring process for medical staff in need. During this study, this process had only been done in RSUD CQ, in the case of the obstetrics/gynecology doctor. The mechanism of proctoring is as follows: The professional quality subcommittee determines the name of the medical staff person who is undergoing disciplinary sanctions or needs to receive clinical privilege deductions. Furthermore, the medical committee coordinates with the head/director of the hospital to facilitate all the necessary resources for the mentoring process (proctoring).

The fulfillments of service standards become important in the JKN system with an INA-CBGs tariff pattern. It needs a clear reference to run the service so that the quality and cost can be controlled. In RSUD AM, a clinical pathway already exists for 15 types of medical services, whereas there are only five in RSUD HA and ten in RSUD CQ (Table 1).. Clinical practice guides have also been created for each hospital and have been translated into Standard Operating Procedures (SPO) (Table 1). In hospitals that have been accredited, SPO are common.

The Full Quality Control Program (*KMKB*) in the era of *JKN* plays a very important role because quality and controlled service costs must be achieved. The medical committee is involved in the *KMKB* team in hospitals that coach medical staff to comply with the established national formulary and service standards. At all hospital research sites, the *KMKB* team has been established and is already running. This team is supervised by an integrated team of BPJS, in which there are professional elements and

clinical experts. The updating of medical resumes is the responsibility of the medical staff, which in this *JKN* is of paramount importance.

The verification of medical resumes at RSUD CQ has been coordinated by the medical committee (Table 1). Therefore, every medical resume is checked first by the medical committee before being sent to the Claim Section. This method is quite effective because it can get the maximum amount of claim, and can avoid medical fraud. RS accreditation is one indicator of RS service quality achievement. Accreditation also affects the role of the medical committee in clinical management of RS in the *JKN* era. In general, the hospital accreditation process is determined by the participation of the medical staff. This also occurs in all three research locations hospitals. Accreditation results in the three hospitals are as follows: RSUD AM accredited middle, RSQ CQ accredited basic, while RSUD HA is still in the process of accreditation (Table 1).

The upgrading of professionalism is conducted by the professional management program and by disciplinary proceedings within the expertise of the environment. Professional disciplinary efforts have never been conducted in AM and HA hospitals because, according to informants, there have never been a case that needs to be addressed. In addition, neither ethical guidance nor professional disciplines have been done to prevent the emergence of problems of ethics/discipline. Unlike RSUD CQ, ethical/disciplinary coaching is done routinely, usually in collaboration with Indonesian Doctors Association (*IDI* Branch). Several cases of disciplinary/ethical violations have been resolved, because only small cases avoid a legal path. It can be resolved by the medical committee through plays a role in managing patient complaints against medical staff, so many problems are resolved before reaching the director's desk.

The ethical/disciplinary tract of the profession at RS in the *JKN* era also includes preventing the emergence of medical fraud. This can be achieved by filling out the correct medical resumes and implementing good quality control and cost control.

DISCUSSION

Compared with similar research, it can be seen that the performance of the medical committee in terms of organizational management is now much better. This is because of a better understanding of Ministry

of Health Regulation No. 755/2011. However, the functional position of the medical committee has not changed much; the medical committee is still involved in management work. According to Herkutanto,¹³ most of the medical committees are involved in management jobs that are not tasks and authorities such as the provision of medicines, medical devices, and so on, and are even involved in discussions of medical services.

A study in 133 hospitals found that the performance of the medical committee in Indonesia was still below expectations, and there is a misperception that the medical committee is a mechanism for fighting for the welfare of doctors. The existence of credential processes, the granting of written clinical authority, professional development, audit systems, professional discipline, and sanctions reflect the performance of the medical committee better than those activities that do not include such things.¹³

In line with several other studies, the credentialing of doctors in hospitals in Indonesia is not working properly and doctors' credentials are confused with the process of employee acceptance.¹⁴ The research in Central Java states that the implementation of the medical committee's task at the hospital is still below expectations even though the organizational structure is on average already good.¹⁵

According to *Permenkes 755/2011*, credentialing is one of the RS's efforts to maintain the standards and competence of medical staff that will deal directly with patients in the hospital. This effort is made by arranging for every medical service performed on patients to be performed only by truly competent medical staff. This competency includes two aspects: the competence of the medical profession consisting of knowledge, skills, and professional behavior, and physical and mental competence.³

In the era of *JKN*, quality and controlled service costs must be accomplished by the medical committee. The team conducts guidance on medical staff to comply with national formularies and established service standards. The replenishment of medical resumes is the responsibility of medical staff, under *JKN* is of paramount importance. Through the INA-CBGs system, the filling of the medical resume will have an impact on the amount of the claim. Therefore, many hospitals employ specialized verifiers for the effectiveness of medical resume filling, including the three RS research sites. In addition, the medical committee is obliged to nurture the ability and ethics of medical staff in order to fill out medical records

appropriately to obtain a representative amount of claim and avoid medical fraud.

Several studies indicate that medical staff under the coordination of the medical committee determines the smoothness of the *JKN* program in hospitals. This includes, for example, the role of medical staff in medical resume filling. Apriyantini's research found that one of the causes of incomplete medical record filling is that medical recorders are not the doctors responsible for doing so, thus the standard procedure has not been implemented optimally, and there is no sustainable socialization system, and no reward and punishment.¹⁶ This is consistent with other research that shows that medical resume completion by specialists in the inpatient ward is still poor and below standard.^{17,18} This is due to the lack of medical compliance with the medical resume, i.e. uniform interpretation of the Doctor in Charge of Services in filling out medical resumes and equivalency with INA-CBGs.¹⁷ Also one of the causes of coding error, potentially harmful to hospital revenues, is due to unreadable and incomplete doctors' written information on medical resume sheets.¹⁹ This very important role of the medical committee is linked to patient safety.

Some research indicates that the incidence of medical errors in some hospitals is quite alarming,^{20, 21} including the potential failure of surgery in a hospital due to an improper transition process.²² That some medication errors in the hospital can be caused by the behavior of doctors, nurses, or drug storage is not true.²³

According to research results of a patient satisfaction assessment of hospital service conducted by the Regional Research and Development Bodies (*Balitbangda*) of Jambi Province in 2015, it is known that 20% of hospital service is not good, especially in terms of interpersonal communication between doctor and patient and between nurse and patient.²⁴ The weakness of this communication can be caused by many factors. The main internal constraints that hinder communication include the availability of resources such as human resources and budget and infrastructure facilities.²⁵ It is also reported that the quality of service proved is able to increase patient satisfaction, meaning the better the quality of health services provided by the RS, the higher the level of patient satisfaction.

In relation to quality management of hospitals in Jambi Province, it is also reported that the performance of general hospitals is still varied while

the performance indicators of major hospitals is less than the mean.²⁶ The role of the medical committee is enormous in realizing a good clinical governance hospital. As shown by research in Batam City,²⁷ clinical governance implemented by stakeholders and providers is still not good enough due to the lack of knowledge about clinical governance and the lack of quantity and quality of resources. Clearly, adequate resources are needed to improve the quality of service.^{28, 29}

In conclusion, the medical committee in general has not played an optimal role in the clinical management of RS in the era of National Health Insurance in Class C General Hospitals in Jambi Province, especially in the processes of credentialing, maintaining professional quality, and guarding the discipline/professional ethics of medical staff. The National Health Insurance System has a good influence on the role of medical committees in the clinical governance of hospitals as there are some that are implementing regulations of *JKN* through integration with the medical committee, especially in the area of quality and cost control.

Recommendations to enhance the role of the medical committee in the clinical governance of hospitals include improving the competence, ethics, and discipline of the medical profession, to improving the capacity of the medical committee and Director of Hospital, and improving the integration of regulations related to *JKN* era clinical administration. Suggestions for the Ministry of Health and the Health Office to enrich and strengthen the integrated regulation of clinical governance of hospitals and to accelerate the process of establishing National Guidelines for Medical Services as a reference in the preparation of service standards in hospitals so that the medical committee can synergize with all clinical care professionals in hospital governance in the era of National Health Insurance.

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