HEALTHE CARE AUSTRALIA PTY LTD

HOSPITAL BY-LAWS

Commercial in confidence

For Implementation from 22 July 2016 (version 3)

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A. OVERVIEW

About Healthe Care

Healthe Care is Australia's largest privately owned private hospital operator. The group currently operates seventeen private hospitals and is continuing to grow.

Healthe Care manages its hospitals through a combination of two key factors: the implementation of a disciplined corporate framework driven by a 'hands on' executive team; and the creation of strong local management teams at each hospital who are empowered to take ownership over localised operational issues.

Healthe Care recognises the very great importance of developing trusting relationships with staff and of partnering with its doctors and other allied health professionals. These By-Laws are an important part of building and ensuring the continuation of a long and trusting relationship that will help achieve Healthe Care's goal of becoming the health care provider of choice for doctors, patients, staff and key stakeholders in Australia.

Healthe Care Values

1. Healthe Care fundamentally believes at its Hospitals it is **"People First People Always".**

2. Healthe Care's objectives are therefore strongly allied to ensuring that their patients, their families and carers receive the best possible care while at a Healthe Care Hospital and that patients receive:

    - High quality medical care;
    - In a safe caring environment;
    - That is efficient and effective.

3. These values should be used to guide the application of the By-Laws.

B. BY-LAWS

What is the function of these By-Laws?

4. Day to day managerial responsibility of Healthe Care Hospitals is delegated by the Board to the Chief Executive Officers of the Hospitals. The By-Laws provide direction from the Board to the Chief Executive Officers in relation to exercise of certain aspects of their managerial responsibility.

5. Medical care at Healthe Care Hospitals is provided by Accredited Practitioners who have been granted access to use the Hospital facilities. The By-Laws define the relationship and obligations between Healthe Care and its Accredited Practitioners.

6. Healthe Care aims to maintain a high standard of patient care and to continuously improve the safety and quality of its Hospital services. The By-Laws implement measures aimed at maintenance and improvements in safety and quality.

7. Health care in Australia is subject to numerous legislation and standards. The By-Laws assist in compliance with certain aspects of this regulation.

What do these By-Laws contain?

8. The By-Laws set out the following:

- The structure and responsibilities of the Hospital Executive.
- The Annual General Meeting of Accredited Practitioners.
- The structure and responsibilities of the Medical Advisory Committee and its sub-committees.
- The procedure for the grant of Accreditation and the scope of the Clinical Privileges that may be exercised by an Accredited Practitioner.
- Conditions on the grant of Accreditation and the clinical responsibilities of Accredited Practitioners.
- The procedure for variation, review, investigation, suspension, termination and reinstatement of Accreditation or Clinical Privileges.
- Initiatives for safety and quality.

Modification of By-Laws

9. From time to time the By-Laws may be modified by the Board of Healthe Care Australia Pty Ltd.

10. Unless otherwise specified by the Board, changes take effect from the time of the resolution by the Board.

11. If the modified By-Laws are to have retrospective effect, this must be specifically stated by the Board, as well as the time that the modifications shall take retrospective effect.

12. The modified By-Laws apply to all Accredited Practitioners and Employed Medical Practitioners, including those Accredited Practitioners and Employed Medical Practitioners engaged or accredited prior to the modification of the By-Laws.

13. The Chief Executive Officer of Healthe Care (or delegate) may approve the annexures that accompany these By-Laws, and amendments that may be made from time to time, and the annexures once approved by the Chief Operating Officer of Healthe Care (or delegate) will form part of the By-Laws.

14. The Board or Chief Executive Officer of Healthe Care (or delegate) may approve terms of reference, policies, procedures and audit tools that are created pursuant to these By-Laws or to provide greater detail and guidance in relation to implementation of aspects of these By-Laws. These may include but are not limited to Accreditation and Delineation of Clinical Privileges requirements and the further criteria and requirements will be incorporated as criteria and requirements of these By-Laws.

Guide to Application of By-Laws

15. In these By-Laws headings are for convenience only and do not affect interpretation.

16. The following rules apply in interpreting these By-Laws, except where the context makes it clear that that a rule is not intended to apply:

- A reference to legislation (including subordinate legislation) is to that legislation as amended, re-enacted or replaced, and includes any subordinate legislation issued under it.

- A reference to a document or agreement, or a provision of a document or agreement, is to that document, agreement or provision as amended, supplemented, replaced or novated.
- A singular word includes the plural, and vice versa.
- A word which suggests one gender includes the other gender.
- If a word is defined, another part of speech has a corresponding meaning.
- If an example is given of something, the example does not limit the scope of that thing.

17. Where a reference is made to a meeting, the following quorum requirements shall apply:

    - Where there is an odd number of members of the committee or group, a majority of the members; or
    - Where there is an even number of members of the committee or group, one half of the number of the members plus one.

18. Where required by these By-Laws, voting shall be on a simple majority voting basis and only by those in attendance at the meeting. There shall be no proxy vote.

19. A decision may be made by a committee or group established pursuant to these By-Laws without a meeting if a consent in writing setting out such a decision is signed by all the committee or group members.

20. A committee or group established pursuant to these By-Laws may hold any meeting by electronic means whereby participants can be heard and can hear but are not necessarily in the same place. The requirements of these By-Laws shall apply to such a meeting.

21. The general guidelines for meetings set out above may be modified by terms of reference approved by the Chief Executive Officer of Healthe Care or Board.

22. Information provided to any committee or person which is provided in confidence shall be regarded as confidential and is not to be disclosed to any third party or beyond the particular forum purposes for which such information is made available, other than as required for internal reporting or advice, by law, or if the interests of patient safety require disclosure.

23. The Chief Executive Officer of Healthe Care may delegate responsibilities conferred upon him/her by the By-laws in his/her complete discretion, but within any delegation parameters approved by the Board.

Contracts of Employment or Engagement

24. Unless specifically determined otherwise by the Chief Executive Officer of Healthe Care in writing for a specified Accredited Practitioner, the provisions of these By-Laws in their entirety prevail to the extent of any terms, express or implied, in a contract of employment or engagement that may be entered into.

25. Subject to a specific written determination by the Chief Executive Officer of Healthe Care as set out in the preceding paragraph, it is a condition of ongoing Accreditation that the Accredited Practitioner agrees that the provisions of these By-Laws prevail to the extent of any inconsistency or uncertainty between the provisions of these By-Laws and any terms, express or implied, in a contract of employment or engagement.

C. DEFINITIONS

Certain words and expressions in these By-Laws are capitalised to indicate a special meaning. Set out below are those special meanings:

- **ACCREDITATION** is the written authorisation from the Chief Executive Officer that the applicant may treat patients at the Hospital within the Accreditation Category, Accreditation Type and Delineation of Clinical Privileges specified in that authorisation.

- **ACCREDITATION CATEGORY** means as part of the Accreditation, the appointment of an Accredited Practitioner to one or more of the following categories: Specialist Practitioner, Staff Specialist, General Practitioner, Consultant Specialist, Consultant General Practitioner, Consultant Emeritus, Employed Medical Officer, Surgical Assistant – Medical or Non-Medical, Nurse Practitioner, Registered Nurse (employed by Specialist Practitioner), Registered Nurse (working in a specialist area), Dentist, Dental Specialist, Allied Health Professional, Other Practitioner or University Student. **Annexure D** contains the model criteria for each Accreditation Category.

- **ACCREDITATION TYPE** means as part of the Accreditation, the appointment of an Accredited Practitioner with one or more of the following: admitting privileges, consulting privileges, assist privileges, anaesthetic privileges, operating privileges and diagnostic privileges.

- **ACCREDITED PRACTITIONER** means a Medical Practitioner (also may be known as a Visiting Medical Practitioner or Officer), Dentist (also may be known as a Visiting Dental Practitioner), Nurse Practitioner, Registered Nurse, Allied Health Professional or Other Practitioner with Accreditation to perform services at the Hospital within the Accreditation Category, Accreditation Type and Delineation of Clinical Privileges notified in the appointment.

- **ACT** means the relevant act (including any regulations) of the State or Territory which is intended to cover the regulation of private hospitals in that State or Territory.

- **ALLIED HEALTH PROFESSIONAL** means chiropractors, dieticians, independent midwives, occupational therapists, pharmacists, physiotherapists, podiatrists, psychologists, speech pathologists, social workers, rehabilitation counsellors or other categories of allied health professionals as determined by the Board.

- **APPLICATION FORM** means the forms approved by the Hospital from time to time to apply for Accreditation at the Hospital (see the annexures to these By-Laws which contain the current application forms).

- **BOARD** means the Board of Directors of Healthe Care.

- **BY-LAWS** means these By-Laws as amended from time to time.

- **CHIEF EXECUTIVE OFFICER** or **CEO** means the person appointed as the senior executive in the Hospital by the Board, and in the absence of that person shall include the person appointed to act in that position.

- **CHIEF EXECUTIVE OFFICER OF HEALTHE CARE** or **CEO OF HEALTHE CARE** means the person appointed as the senior executive of Healthe Care by the Board, and in the absence of that person shall include the person appointed to act in that position.

- **CLINICAL PRIVILEGES** means the specific medical services, surgical or dental procedures, or other clinical services permitted to be undertaken by an Accredited Practitioner at the Hospital.

- **CONSULTANT EMERITUS** means a Medical Practitioner or Dentist who has provided distinguished service to the Hospital and who has retired from active practice or is otherwise a member of the medical or dental profession of outstanding merit or extraordinary accomplishment.

- **CONSULTANT GENERAL PRACTITIONER** means a Medical Practitioner who has been recognised as a general practitioner for the purposes of the Health Insurance Act 1973 (Commonwealth), is registered as such by the relevant registration body and following grant of Accreditation may consult and treat patients who are under the care of Specialist Practitioners with admitting rights.

- **CONSULTANT SPECIALIST** means a Medical Practitioner who has been recognised as a specialist in their nominated category for the purpose of the Health Insurance Act 1973 (Commonwealth), is recognised by the relevant specialist college, is registered as such by the relevant registration body and following grant of Accreditation may consult and treat patients who are under the care of Specialist Practitioners with admitting rights.

- **COMPETENCE** means, in respect of a person who applies for Accreditation, that the person is possessed of the necessary aptitude in the application of knowledge and skills in decision making, judgement, Performance and interpersonal relationships necessary for the Clinical Privileges for which the person has applied and has demonstrated ability to provide health services at an expected high level of safety and quality.

- **CREDENTIALS** means, in respect of a person who applies for Accreditation, the qualifications; professional training; knowledge, training and experience in leadership, research, education, communication and teamwork; clinical experience; Competence; Current Fitness; character; and other professional attributes of the applicant, that contribute to the person's professional suitability and confidence held in the ability to provide safe, competent, ethical, and high quality health care services within the Clinical Privileges sought to be exercised at the Hospital. The applicant's history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal history, as well as Organisational Capability and Organisational Need, are factors to be considered in assessing their Credentials for the Hospital.

- **CREDENTIALING** means, in respect of a person who applies for Accreditation, the formal process used to verify the qualifications; professional training; knowledge, training and experience in leadership, research, education, communication and teamwork; clinical experience; Competence; Current Fitness; character; and other professional attributes of the applicant, that contribute to the person's professional suitability and confidence held in the ability to provide safe, competent, ethical, and high quality health care services within the Clinical Privileges sought to be exercised at the Hospital.

- **CREDENTIALS AND CLINICAL PRIVILEGES COMMITTEE** means the committee established pursuant to these By-Laws.

- **CURRENT FITNESS** is the current fitness required of an applicant Accredited Practitioner to carry out the Clinical Privileges sought or currently held. A person is not to be considered as having current fitness if that person suffers from a physical or mental impairment, disability, condition or disorder which detrimentally affects or is likely to detrimentally affect the person's physical or mental capacity to safely practice medicine or dentistry or allied health or nursing (as the case may be) and carry out the Clinical Privileges sought or granted. Habitual drunkenness or addiction to drugs is considered to be a physical or mental disorder.
- **DELINEATION OF CLINICAL PRIVILEGES** means the limitations on the scope or extent of the Clinical Privileges that may be exercised by an Accredited Practitioner at the Hospital as notified in the appointment based on the applicant's Credentials, and the

Organisational Capability and Organisational Need of the Hospital to support the Accredited Practitioner's scope of clinical practice. **Annexures E and J** contain model criteria to be used in determining the Delineation of Clinical Privileges for a particular Accredited Practitioner at a particular Hospital.

- **DENTAL SPECIALIST** has the same meaning as in the registration act regulating dentists in the State or Territory, or as recognised by the registration board regulating dentists in the State or Territory.

- **DENTIST** has the same meaning as in the registration act regulating dentists in the State or Territory.

- **DIRECTOR OF MEDICAL SERVICES** (also known as a Medical Director or Medical Superintendent) means, if the Chief Executive Officer decides to make an appointment to such a position, the person appointed by the Chief Executive Officer to that position, and in the absence of that person the person appointed to act in that position.

- **DIRECTOR OF CLINICAL SERVICES** (also known as the Director of Nursing) means the person appointed by the Chief Executive Officer to that position, and in the absence of that person the person appointed to act in that position.

- **EMPLOYED MEDICAL OFFICER** means a Medical Practitioner who is an employee of the Facility and is engaged pursuant to a contract of employment, who may consult and treat patients under the supervision of a Specialist Practitioner or Staff Specialist but may not admit patients to the Hospital.

- **EXECUTIVE MANAGEMENT COMMITTEE** means the executive committee (if any) established under these By-Laws.

- **EXECUTIVE STAFF** means executive staff appointed under these By-Laws.

- **FELLOW PRACTITIONER** means a Medical Practitioner not yet recognised as a specialist in their nominated category for the purpose of the Health Insurance Act 1973 (Commonwealth), but who is training to become a specialist in a nominated category and working in that specialty under the supervision of a Specialist Practitioner, and is not permitted to admit patients to the Hospital.

- **GENERAL PRACTITIONER** means a Medical Practitioner who has been recognised as a general practitioner for the purposes of the Health Insurance Act 1973 (Commonwealth), who is registered as such by the relevant registration body and who may admit patients to the Hospital.

- **HEALTH DEPARTMENT** means the Department of Government with the responsibility for health in the State or Territory in which the Hospital is located.

- **HEALTHE CARE** means Healthe Care Australia Pty Ltd and its subsidiaries.

- **HOSPITAL** means the particular facility owned and operated by Healthe Care.

- **MEDICAL ADVISORY COMMITTEE** means the medical advisory committee established pursuant to these By-Laws.

- **MEDICAL PRACTITIONER** has the same meaning as in the registration act regulating medical practitioners in the State or Territory.

- **NURSE PRACTITIONER** means a Registered Nurse who is registered as a nurse practitioner by the relevant registration body, and who is educated to function autonomously and collaboratively in an advanced and expanded clinical nursing role.

- **OTHER PRACTITIONER** means health practitioners seeking Accreditation not falling into another Accreditation Category, including visiting complimentary or natural therapy providers.

- **ORGANISATIONAL CAPABILITY** means the Hospital's ability to provide the facilities, services and clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational Capability will include consideration of the availability, limitations and/or restrictions of the services, licensing, staffing, facilities, equipment, and support services at the Hospital.

- **ORGANISATIONAL NEED** means the extent to which the Hospital is required or seeks to provide a specific clinical service, procedure or other intervention in order to provide a balanced mix of safe, high quality health care services that meet Healthe Care, the Hospital, consumer and community needs and requirements. Organisational Need will include consideration of the strategic direction of Healthe Care and the Hospital, current resource allocation, assessment of financial viability and the need for the new service or for additional services of that type.

- **PATIENT CARE REVIEW COMMITTEE** means the committee (if any) established pursuant to these By-Laws.

- **PERFORMANCE** means the extent to which an Accredited Practitioner provides health care services in a manner which is consistent with known good clinical practice and results in expected patient benefits.

- **REGISTERED NURSE** has the same meaning as the applicable registration legislation for registered nurses in the State or Territory.

- **REGISTERED NURSE (employed by Specialist Practitioner)** means a Registered Nurse visiting the Hospital and employed by a Specialist Practitioner.

- **REGISTERED NURSE (working in a specialist area)** means a Registered Nurse visiting the Hospital and working in a specialist area.

- **REGULATION** means a regulation made under the Act.

- **SPECIALIST PRACTITIONER** means a Medical Practitioner who has been recognised as a specialist in their nominated category for the purpose of the Health Insurance Act 1973 (Commonwealth), is recognised by the relevant specialist college, is registered as such by the relevant registration body and following grant of Accreditation may admit patients to the Hospital.

- **STAFF SPECIALIST** means a Specialist Practitioner appointed to and employed by or seconded to the Hospital.

- **STATE** means the State (or Territory) in which the Hospital operates.

- **SURGICAL ASSISTANT** means a health professional who assists under the direct supervision of a Specialist Practitioner in the pre-operative assessment, operating theatre and immediate post-operative care, but is unable to initiate or change treatment orders or patient management.

D. STRUCTURE AND RESPONSIBILITIES OF HOSPITAL EXECUTIVE

Chief Executive Officer

26. The Board shall appoint a Chief Executive Officer of the Hospital.

27. The Chief Executive Officer shall:

    (a) be the senior officer of the Hospital to whom all staff shall be responsible;

    (b) be the spokesperson and channel for all communications to and from the Hospital;

    (c) advise the Board on matters relating to the purchase of major equipment;

    (d) be responsible for the management and patient care of the Hospital, its facilities, staff and resources, to acceptable standards in accordance with the policies and directives of the Board;

    (e) ensure due observance of the Act, all other statutes, Department instructions and determinations, these By-Laws and all other legal requirements; and

    (f) act as Secretary to the Medical Advisory Committee, Credentials and Clinical Privileges Committee and Patient Care Review Committee. However, if a Director of Medical Services is appointed, the Chief Executive Officer may delegate such role to the Director of Medical Services.

Director of Medical Services

28. The Chief Executive Officer may appoint a Director of Medical Services.

29. The Director of Medical Services shall be responsible to the Chief Executive Officer for:

    (a) ensuring that suitable clinical standards are maintained to provide a satisfactory and safe environment for patients, visitors and staff;

    (b) advising on, and participating in, safety and quality initiatives;

    (c) advising on, and overseeing, continuing education and training programs for staff and Accredited Practitioners;

    (d) assisting in the management of incidents and open disclosure;

    (e) advising the Board, through the Chief Executive Officer, on matters of policy in relation to medical services;

    (f) overseeing the process of Accreditation of Accredited Practitioners;

    (g) ensuring that medical staff are provided at a level to maintain a safe and optimum level of patient care;

    (h) ensuring compliance with the relevant statutory requirements;

    (i) actively participating in all activities of the Executive Management Committee; and

(j) ensuring availability at all times, either personally or by the delegation, to meet any emergency or contingency that may arise.

If a Director of Medical Services is appointed, the Chief Executive Officer may delegate the roles of Secretary to the Medical Advisory Committee, the Credentials and Clinical Privileges Committee, and the Patient Care Review Committee to the Director of Medical Services.

Director of Clinical Services

30. The Chief Executive Officer shall appoint a Director of Clinical Services on such terms and conditions as are consistent with statutory requirements.

31. The Director of Clinical Services shall be responsible to the Chief Executive Officer for:

(a) ensuring that suitable standards (including but not limited to clinical standards) are maintained to provide a satisfactory and safe environment for both patients and staff;

(b) advising on, and participating in, safety and quality initiatives;

(c) advising on, and overseeing, continuing education initiatives;

(d) assisting in the management of incidents and open disclosure;

(e) advice on matters of nursing and relevant clinical policies;

(f) ensuring that nursing staff are provided at a level that will ensure a safe and optimum level of patient care;

(g) ensuring compliance with relevant statutory requirements;

(h) co-operating in the planning of additional services (as required);

(i) ensuring availability at all times, either personally or by delegation, to meet any emergency or contingency that may arise.

Executive Staff

32. The Chief Executive Officer may appoint any other executive staff members he or she deems appropriate for the Hospital, including determining the role of such an appointment.

Executive Management Committee

33. The Executive Management Committee shall be responsible for financial, staff, operational, clinical and strategic matters relevant to the Hospital. The committee shall comprise at a minimum:

(a) the Chief Executive Officer;

(b) if a Director of Medical Services is appointed, the Director of Medical Services;

(c) the Director of Clinical Services;

(d) other Executive Staff; and

(e) any other person by invitation from the Chief Executive Officer.

Hospital Committees

34. With the exception of the Medical Advisory Committee, the Executive Management Committee may establish committees to assist in the management and operations of the Hospital. Subject to the agreement of the Chief Executive Officer, the Executive Management Committee shall:

    (a) determine the membership of a committee;

    (b) determine the terms of reference of a committee;

    (c) determine rights of attendance at a committee;

    (d) determine committee voting;

    (e) determine minimum meeting requirements; and

    (f) determine other matters pertaining to the appropriate operation or reporting of the committee.

E. ANNUAL GENERAL MEETING

35. All Accredited Practitioners appointed to the Hospital shall be entitled to attend and participate at the Annual General Meeting.

36. The objectives of the Annual General Meeting shall be to:

    (a) provide a general forum for communication between the Board, Executive Management Committee, and Accredited Practitioners to facilitate the safe provision of medical, dental and allied health services at the Hospital;

    (b) elect or endorse the nominated Accredited Practitioners to the Medical Advisory Committee.

37. There shall be appointed at the Annual General Meeting at least five Accredited Practitioners to be members of the Medical Advisory Committee, as follows:

    (a) the appointees will be Medical Practitioners or Dentists;

    (b) the appointees will be made up of a majority of Medical Practitioners,

    (c) where possible, the appointees will include at least one representative from each of the major specialty groups of the Hospital (the major specialty groups shall be determined by the Chief Executive Officer after consultation with the Chairperson of the Medical Advisory Committee).

38. Only active Accredited Practitioners shall be eligible to vote and stand for office for the Medical Advisory Committee. An active Accredited Practitioner is an Accredited Practitioner (other than Consultant Emeritus) who utilises the Hospital on a regular basis, with the criteria as determined by the Chief Executive Officer after consultation with the Chairperson of the Medical Advisory Committee on the basis of an assessment of activity over the prior 6 month period.

39. Annual General Meetings shall be held once in every calendar year and not more than 15 months after the last Annual General Meeting.

40. Written notice of the Annual General Meeting, together with a copy of the agenda for that meeting, shall be given not less than 14 days prior to the date of the meeting.

41. Proceedings at the Annual General Meeting are as follows:

    (a) The chairperson at the Annual General Meeting will be the current chairperson of the Medical Advisory Council.

    (b) Entitlement to vote is given only to those Accredited Practitioners who are in the attendance at the Annual General Meeting. There shall be no proxy vote.

    (c) All questions shall be decided by majority by show of hands, or where demanded by a member entitled to vote, a ballot.

    (d) The chairperson of the Annual General Meeting shall have a casting vote.

    (e) Minutes of the Annual General Meeting shall be recorded by the Chief Executive Officer or delegate.

    (f) Minutes shall be distributed to all those entitled to attend meetings of the Annual General Meeting.

    (g) Minutes of the meeting shall be confirmed and signed by the chairperson of the Annual General Meeting, and minutes so confirmed and signed shall be taken as evidence of the meeting.

F. MEDICAL ADVISORY COMMITTEE

Appointment

42. The Medical Advisory Committee shall, in addition to those Accredited Practitioners appointed at the Annual General Meeting, comprise the Chief Executive Officer, Director of Medical Services (if the Hospital has a Director of Medical Services), and Director of Clinical Services, as ex-officio members.

43. Unless determined otherwise by the Chief Executive Officer, the Medical Advisory Committee will be comprised of a minimum of 5 Accredited Practitioners, including where possible in the circumstances at least one representative from each of the major speciality groups of the hospital.

44. Accredited Practitioners elected to the Medical Advisory Committee will be elected at the Annual General Meeting.

45. Only current Accredited Practitioners, who are in attendance at the Annual General Meeting, are eligible to vote to appoint members of the Medical Advisory Committee and there will be no proxy votes permitted.

46. Only current Accredited Practitioners are eligible to stand for office in relation to the Medical Advisory Committee.

47. The Chief Executive Officer will retain the discretion to exclude an Accredited Practitioner from standing for office for appointment to the Medical Advisory Committee.

48. Voting will be determined on a majority basis and, in the event a deciding vote is required, the current chairperson of the Medical Advisory Committee will have the deciding vote.

49. The Accredited Practitioners appointed at the Annual General Meeting are appointed for a period of two years that commences from the date of the Annual General Meeting at which they are appointed.

50. Unless determined otherwise by the Chief Executive Officer, no Accredited Practitioner appointed to the Medical Advisory Committee shall serve for more than 6 consecutive years.

51. Unless determined otherwise by the Chief Executive Officer, the chairperson of the Medical Advisory Committee shall serve in the position as chairperson for no more than 4 consecutive years and the chairperson will be elected by the current Accredited Practitioner members of the Medical Advisory Committee.

52. Members of the Medical Advisory Committee and Sub-Committees will be indemnified by Healthe Care through its insurance program, in accordance with the terms and conditions of that insurance (which will be made available upon request), and subject to the person acting in accordance with the By-Laws (including the role and responsibilities specified in the By-Laws and any position description), within the terms of reference, and in good faith.

Resignation from Membership of Medical Advisory Committee

53. Any member of the Medical Advisory Committee may resign from such membership by giving at least one month's notice in writing of their intention to resign to the Chief Executive Officer.

54. If the resignation occurs more than two months prior to the next Annual General Meeting, the Chief Executive Officer, after consulting with the chairperson of the Medical Advisory Committee, will nominate a replacement to act in that capacity until the next formal election.

Expiry of Appointment to Medical Advisory Committee

55. If the appointment of a member of the Medical Advisory Committee expires prior to the time of holding the next Annual General Meeting, the appointment will unless determined otherwise by the Medical Advisory Committee be automatically extended to the time of the next Annual General Meeting.

Power to Co-opt

56. The Medical Advisory Committee may co-opt the services of any other person should it consider this necessary, however, that person or persons shall have no voting rights at a meeting of the Medical Advisory Committee or any of its sub-committees.

Role of Medical Advisory Committee

57. The Medical Advisory Committee shall, unless specified otherwise in the specific terms of reference for the Medical Advisory Committee of a particular Hospital, advise the Chief Executive Officer, and:

    (a) be the formal organisational structure through which the collective views of the Accredited Practitioners of the Hospital shall be formulated and communicated;

    (b) provide a forum for two-way communication between the Hospital Executive and Hospital and the Accredited Practitioners, Hospital Sub-Committees and Specialty Groups to facilitate the safe provision of patient services;

(c) provide a means whereby Accredited Practitioners can advise the Hospital Executive of appropriate policies regarding the clinical organisation of the Hospital;

(d) plan and manage a continuing education program for members of the junior medical staff, where appropriate;

(e) refer clinical and quality matters with National-wide concerns or implications;

(f) assist in identifying health needs of the community and advise the Hospital on appropriate services which may be required to meet these needs;

(g) endeavour to ensure that the delivery of patient care in the Hospital is maintained at an optimal level based on current best practice and research;

(h) establish and maintain a formal mechanism for review of clinical outcomes and clinical management, including a peer review process;

(i) where within the knowledge of the members of the Medical Advisory Committee, bring to the attention of the Hospital Executive any issues in relation to the observance of the Act, all other statutes, Department instructions and determinations, and all other legal requirements;

(j) review any new or amended use of technology or procedures to treat patients, assessing the facilities of the Hospital and other matters which are relevant, and make a recommendation on the amendment of the Clinical Privileges of an Accredited Practitioner;

(k) ensure that applicants for Accreditation are appropriately qualified for appointment as Accredited Practitioners consistent with the terms and conditions set out in these By-Laws

(l) consider applications for appointment or re-appointment as an Accredited Practitioner in accordance with the terms and conditions of these By-Laws, including model criteria, and to make recommendations to the Chief Executive Officer on the Accreditation, Accreditation Category, Privilege Type and Delineation of Clinical Privileges, including recommendations as to any terms or conditions that should attach to an approval of Accreditation ;

(m) if delegated, to review the recommendations of the Credentials and Clinical Privileges Committee or other sub-committee in relation to applications for appointment or re-appointment as an Accredited Practitioner in accordance with the terms and conditions of these By-Laws, including model criteria, and to make recommendations to the Chief Executive Officer on the Accreditation, Accreditation Category, Accreditation Type and Delineation of Clinical Privileges, including recommendations as to any terms or conditions that should attach to an approval of Accreditation;

(n) consider, and if delegated review the recommendations of the Credentials and Clinical Privileges Committee relating to, applications by an Accredited Practitioner for the variation of his or her Clinical Privileges and to make a recommendation to the Chief Executive Officer;

(o) consider, and if delegated review the recommendations of the Credentials and Clinical Privileges Committee relating to, the review, suspension or termination of the Accreditation and/or Clinical Privileges of an Accredited Practitioner, where the Chief Executive Officer has directed the Medical Advisory Committee or

Credentials and Clinical Privileges Committee to assist, and to make a recommendation to the Chief Executive Officer; and

(p) act within the terms of reference approved by the Chief Executive Officer and any legislative obligations imposed upon the Medical Advisory Committee within a particular State. If there is a conflict between these By-laws and any legislative obligations imposed upon the Medical Advisory Committee within a particular State, the legislative obligations will prevail to the extent of the inconsistency.

Meetings of Medical Advisory Committee

58. The meetings will be conducted as follows:

(a) Ordinary meetings of the Medical Advisory Committee shall be held not less than four times a year at a time and place to be determined by the chairperson in consultation with the Chief Executive Officer.

(b) At least 14 days notice shall be given of every ordinary meeting.

(c) A special meeting of the Medical Advisory Committee may be called by the chairperson of the Medical Advisory Committee, subject to the approval of the Chief Executive Officer.

(d) At least 7 days notice of a special meeting shall be given to all members of the Medical Advisory Committee entitled to attend such a meeting.

(e) Notice of a special meeting shall specify the business to be considered and no business of which notice has not been given shall be considered at such a meeting.

(f) Should there be an emergency situation at any time in which it is ordinarily a requirement to obtain the advice of the Medical Advisory Committee, the Chief Executive Officer shall be empowered to undertake such appropriate action for later consideration by the Medical Advisory Committee.

(g) No office bearer of the Medical Advisory Committee nor any of its members or sub-committees shall represent in any way that they represent Healthe Care or the Hospital in any circumstances unless with the express written permission of the Chief Executive Officer. Hospital letterhead shall only be used for official purposes and not for any other purposes.

Proceedings of Medical Advisory Committee

59. Proceedings will be conducted as follows:

(a) Entitlement to vote at meetings of the Medical Advisory Committee is given to the Accredited Practitioner members of the Committee.

(b) All decisions shall be decided by a majority by a show of hands, or where demanded by a member entitled to vote a ballot, and the chairperson of the Medical Advisory Committee shall have a casting vote.

(c) Minutes of all meetings of the Medical Advisory Committee shall be recorded by the Chief Executive Officer or delegate (which may include the Director of Medical Services if a Director of Medical Services is appointed).

(d) Minutes shall be distributed to all those entitled to attend meetings of the Medical Advisory Committee prior to the next meeting.

(e) No business shall be considered at a meeting of the Medical Advisory Committee until the minutes of the previous meeting have been confirmed or otherwise disposed of. No discussion of the minutes shall be permitted except as to their accuracy.

(f) Minutes of a meeting shall be confirmed by resolution and signed by the chairperson at the next meeting and minutes so confirmed and signed shall be taken as evidence of proceedings.

(g) Documentation, minutes and reports will be recorded in accordance with any agenda, minutes and other forms approved by the Chief Executive Officer.

G. ACCREDITATION

Principles

60. The following principles should be considered and guide the making of decisions in the Credentialing and Accreditation process:

(a) Credentialing and Accreditation are organisational governance responsibilities that are conducted with the primary objective of maintaining and improving the safety and quality of health care services;

(b) Processes of Credentialing and Accreditation are complemented by registration requirements and individual professional responsibilities that protect the community;

(c) Effective processes of Credentialing and Accreditation benefit patients, communities, health care organisations and health care professionals;

(d) Credentialing and Accreditation are essential components of a broader system of organisational management of relationships with health care professionals;

(e) Credentialing and Accreditation and any reviews should be a non-punitive process, with the objective of maintaining and improving the safety and quality of health care services;

(f) Processes for Credentialing and Accreditation Privileges depend for their effectiveness on strong partnerships between health care organisations and professional colleges, associations and societies;

(g) Processes of Credentialing and Accreditation should be fair, transparent and legally robust, with the By-Laws drafted to accommodate these principles, therefore compliance with the By-Laws and its processes is important.

61. Credentialing and Accreditation processes apply to all Medical Practitioner, Dentists and Allied Health Professionals seeking to practise or exercise Clinical Privileges at Healthe Care Hospitals.

Credentials and Clinical Privileges Committee

62. Applications for Accreditation will be initially considered by the Credentials and Clinical Privileges Committee.

63. The Credentials and Clinical Privileges Committee shall be comprised as follows:

(a) at least three Accredited Practitioners appointed annually by the Medical Advisory Committee and who are members of the Medical Advisory Committee; and

(b) if the person seeking Accreditation is not of the same speciality as any member of the Credentials and Clinical Privileges Committee, where possible and practicable the Medical Advisory Committee will appoint, for the purpose of considering that particular application, an active Accredited Practitioner of the same speciality. This requirement does not apply if there is not currently an active Accredited Practitioner of the same specialty. An active Accredited Practitioner is an Accredited Practitioner (other than Consultant Emeritus) who utilises the Hospital on a regular basis as determined by the Chief Executive Officer after consultation with the Medical Advisory Committee on the basis of an assessment of activity over the prior 6 month period.

Role of Credentials and Clinical Privileges Committee

64. The Credentials and Clinical Privileges of Committee shall make recommendations to the Medical Advisory Committee.

65. The duties of the Credentials and Clinical Privileges Committee shall be to:

(a) consider applications for appointment and re-appointment as Accredited Practitioners to the Hospital, including investigate as appropriate and verify (where possible from primary source documents), and give due consideration to the Credentials of an application for Accreditation, and make recommendations to the Medical Advisory Committee on the Accreditation, Accreditation Category, and Accreditation Type;

(b) consider the Delineation of Clinical Privileges commensurate with the Credentials, Organisational Capability and Organisational Need, and make recommendations to the Medical Advisory Committee about the Delineation of Clinical Privileges;

(c) make recommendations as to any terms or conditions that should attach to an approval of Accreditation;

(d) where directed by the Medical Advisory Committee and/or Chief Executive Officer, investigate specific matters relevant to the Credentials and confidence in an applicant for appointment or re-appointment as an Accredited Practitioner. Following such investigation, report to the Medical Advisory Committee and/or Chief Executive Officer and make such recommendations as are requested;

(e) where directed by the Chief Executive Officer, develop model criteria for each Accreditation Category and model criteria for the Delineation of Clinical Privileges, and make recommendations to the Medical Advisory Committee about the model criteria;

(f) consider applications by an Accredited Practitioner for the variation of his or her Clinical Privileges and make a recommendation to the Medical Advisory Committee as to the variation sought; and

(g) where directed by the Chief Executive Officer, examine and investigate the current Accreditation and/or Clinical Privileges of an Accredited Practitioner and, following due consideration make a recommendation to the Chief Executive Officer, via the Medical Advisory Committee, in accordance with the terms of reference of the review.

Meetings and Proceedings of the Credentials and Clinical Privileges Committee

66. The meetings and proceedings for the Credentials and Clinical Privileges Committee will be in the same manner as for the Medical Advisory Committee as set out in these By-Laws.

67. The Chief Executive Officer, Director of Medical Services (if the Hospital has appointed a Director of Medical Services) and Director of Clinical Services shall have the right to attend at meetings of the Credentials and Clinical Privileges Committee to make submissions but shall not have the right to vote at such meetings.

Delineation of Clinical Privileges, Defining the Scope of Practice

68. Each person appointed as an Accredited Practitioner to the Hospital shall be appointed to one or more of the following **Accreditation Categories** in accordance with the Model Criteria in Annexure D:

(a) Specialist Practitioner;

(b) Staff Specialist;

(c) General Practitioner;

(d) Consultant Specialist or Consultant General Practitioner;

(e) Consultant Emeritus;

(f) Employed Medical Officer;

(g) Nurse Practitioner;

(h) Registered Nurse (employed by Specialist Practitioner)

(i) Registered Nurse (working in a specialist area)

(j) Surgical Assistant – Medical or Non-Medical;

(k) Dentist;

(l) Dental Specialist;

(m) Allied Health Professional;

(n) Other Practitioner;

(o) University Student;

with one or more of the following **Accreditation Types**:

(i) admitting privileges;

(ii) consulting privileges;

(iii) assist privileges;

(iv) anaesthetic privileges;

(v) operating privileges;

(vi) diagnostic privileges;

(vii) allied health privileges.

69. Each person receiving Accreditation will also be informed of the Delineation of Clinical Privileges at the Hospital and this will be determined in accordance with the Healthe Care Corporate Policy 'Delineation of Clinical Privileges' and with guidance from Annexure C and the model criteria in Annexures E and J.

70. If the circumstances warrant, the Chief Executive Officer may approve a variation of the above Accreditation Category and/or Accreditation Type for a specific applicant in order to accommodation the specific circumstances of an applicant

Term of Appointment of Accredited Practitioners

71. All appointments to a position of Accredited Practitioner shall, unless otherwise determined by the Chief Executive Officer, be for a period of up to five years.

72. Approvals of Accreditation may be subject to specified terms and conditions, or a probationary period, which may result in the Accreditation being for a shorter period of time or which may result in the period of Accreditation concluding at an earlier time pursuant to those terms and conditions.

Application Form

73. The Chief Executive Officer shall provide each Medical Practitioner or Dentist seeking appointment or re-appointment as an Accredited Practitioner with an Application Form – Medical, shall provide each Allied Health Professional seeking appointment or re-appointment as an Accredited Practitioner with an Application Form – Allied, and shall provide each other category of applicant with the appropriate form, that the applicant must submit when seeking appointment as an Accredited Practitioner. The Chief Executive Officer will also make available a copy of the By-Laws to the applicant.

Confidentiality

74. The process involved in Accreditation is confidential and is not to be disclosed outside the Credentials and Clinical Privileges Committee, Medical Advisory Committee, Executive Management Committee or the Board, other than with the permission of the applicant (for example where external inquiries are required in relation to the application), for the purpose of seeking advice or assistance, or as required pursuant to a lawful request or requirement.

Process of Application for Accreditation

75. A Medical Practitioner, Dentist or Allied Health Professional seeking Accreditation or Re-Accreditation as an Accredited Practitioner shall complete the Application Form – Medical or Dentist Application Form (Annexure A1) or Health Professional Application Form (Annexure A2), and other applicants will be provided with a form appropriate for the type of application being made.

76. Applications should be forwarded to the Chief Executive Officer at least 2 months prior to an applicant seeking to commence at the Hospital or at least 2 months prior to the expiration of the current Accreditation. Where this timeframe is unable to be achieved, relaxation of the time period will be at the sole discretion of the Chief Executive Officer.

77. The Application Form is to be completed in its entirety, with all requirements complied with, and the Application Form is to be provided to the Chief Executive Officer.

78. Any Application Form that is not completed in its entirety, including a failure to supply requested information and supporting documents, will be rejected by the Chief Executive Officer unless the Chief Executive Office considers that a reasonable explanation has been provided for the applicant being unable to complete any part of the Application Form. This determination is entirely within the discretion of the Chief Executive Officer. If the application is accepted this does not affect the determination of the Credentials and Clinical Privileges Committee or Medical Advisory Committee about the adequacy of the information provided.

79. If available in the relevant State, the applicant should also make available a letter of 'good standing' from the relevant registration board relating to the applicant.

Consideration of Application Form

80. Following receipt of a completed Application Form:

(a) the Chief Executive Officer shall refer the Application Form to the Credentials and Clinical Privileges Committee;

(b) at the time of requesting an Application Form, or otherwise at the time of receipt of a completed Application Form, the applicant will be provided with a copy of these By-Laws;

(c) the Credentials and Clinical Privileges Committee shall review the application in accordance with the requirements of these By-Laws and make recommendations as to the Accreditation or Re-Accreditation, Accreditation Category, Accreditation Types, the Delineation of Clinical Privileges, and any terms or conditions that should attach to an approval of Accreditation;

(d) The Credentials and Clinical Privileges Committee shall forward its recommendations to the Medical Advisory Committee;

(e) the Medical Advisory Committee shall review the application in accordance with the requirements of these By-Laws and make recommendations as to the Accreditation or Re-Accreditation, Accreditation Category, Accreditation Types, Delineation of Clinical Privileges, and any terms or conditions that should attach to an approval of Accreditation;

(f) The Medical Advisory Committee shall forward its recommendations to the Chief Executive Officer;

(g) At any time during this process the Chief Executive Officer (or delegate), Credentials and Clinical Privileges Committee (or a representative), or Medical Advisory Committee (or representative) may request an interview of the applicant or request further information, documentation or clarification from the applicant or seek consent to contact a third party in order to fully consider and investigate the application, and a time period for response may be specified. The applicant is required to comply with such requests in order for the application to proceed;

(h) The Chief Executive Officer is not bound by any recommendations of the Credentials and Clinical Privileges Committee or Medical Advisory Committee, and may have regard to matters outside of the criteria established for consideration by the Credentials and Clinical Privileges Committee or Medical

Advisory Committee if considered by the Chief Executive Officer to be relevant to the determination;

(i) The Chief Executive Officer shall make a final determination as to the application within fourteen days of receipt of the Medical Advisory Committee recommendations;

(j) The Chief Executive Officer shall notify the applicant in writing of such decision within seven days of making the final determination. The notification will ordinarily follow the format of that annexed to the By-Laws (Annexures F and G);

(k) The Chief Executive Officer will ensure that information relating to the Accreditation Category, Accreditation Type, and Delineation of Clinical Privileges for each Accredited Practitioner is accessible to those providing clinical services within the Hospital.

Guidance for the review and consideration process is contained in Annexure K.

Temporary Appointment

81. The Chief Executive Officer may approve a temporary appointment as Accredited Practitioner (where possible, after referral to the chairperson of the Medical Advisory Committee for comment) and may grant Clinical Privileges to such temporarily appointed Accredited Practitioner.

82. Temporary appointment as an Accredited Practitioner shall be notified in writing by the standard letter for temporary appointments annexed to the By-Laws (Annexure H).

83. Temporary Clinical Privileges shall remain in force until the determination by the Chief Executive Officer of an application for Accreditation following receipt of the recommendations from the Medical Advisory Committee (with the Medical Advisory Committee receiving recommendations from the Credentials and Clinical Privileges Committee) or for a period not exceeding three months.

84. Temporary appointment may be terminated by the Chief Executive Officer at any time for failure to comply with the terms of appointment or these By-Laws.

Emergency Appointment

85. In the case of an emergency, a Medical Practitioner, to the extent permitted by the terms of that Medical Practitioner's registration, may request emergency appointment in order to continue the provision of treatment and care to patients.

86. Emergency appointment may be considered by the Chief Executive Officer (or delegate) for short notice requests to ensure continuity and safety of care for patients and/or to meet Organisational Need.

87. At a minimum, the following is required:

(a) Verification of identify through inspection of relevant documents (e.g. driver's licence with photograph);

(b) Immediate contact with a member of senior management of an organisation nominated by the Medical Practitioner as their most recent place of Accreditation to verify employment or appointment history;

(c) Verification of professional registration and insurance as soon as practicable; and

(d) Confirmation of at least one professional referee of the Medical Practitioner's Competence and good standing as soon as practicable.

88. Emergency appointment will be followed as soon as practicable with temporary appointment or an application for Accreditation, if required.

89. Emergency appointment will be approved for a limited period as identified by the Chief Executive Officer (or delegate) for the safety of the patient, and will automatically terminate at the expiry of that period or as otherwise determined by the Chief Executive Officer.

Locum Appointment

90. Should an Accredited Practitioner wish to appoint a locum tenens to cover a period of absence they shall advise the Chief Executive Officer in adequate time to enable consideration of the appointment of that practitioner as a locum tenens and such appointment may be on a temporary basis for up to three months.

91. Such appointment shall only be made by the Chief Executive Officer after referral to the chairperson of the Medical Advisory Committee for comment.

92. For the avoidance of doubt, the locum tenens must be an Accredited Practitioner accredited under these By-Laws, and may have a Temporary Appointment.

93. Should an Accredited Practitioner wish to take a period of absence from their appointment they shall advise the Chief Executive Officer of such proposed absence by the provision of reasonable notice. In the ordinary course of events this will not be less than 1 months notice.

Appeal Rights

94. There shall be no right of appeal by an applicant against a decision not to grant an initial appointment as an Accredited Practitioner to the Hospital or from any terms or conditions that may be attached to an approval of an initial appointment as an Accredited Practitioner at the Hospital.

95. There shall be no right of appeal if an approval of an initial appointment as an Accredited Practitioner at the Hospital included an initial probationary period and at the conclusion of the probationary period the Chief Executive Officer determined that Accreditation would not be granted following conclusion of the probationary period. In such circumstances the Accredited Practitioner will be required, if they seek Accreditation at the Hospital, to make a further application for Accreditation that will be regarded as an application for an initial appointment as an Accredited Practitioner at the Hospital.

96. There shall be no right of appeal against a decision not to grant a temporary, emergency or locum appointment.

97. There shall be no right of appeal against a decision not to introduce a new or amended use of technology or procedure.

98. Should an applicant holding a current appointment as an Accredited Practitioner have that appointment rejected, either in whole or in part or varied by the Chief Executive Officer, the applicant shall have the rights of appeal set out within these By-Laws in the section

Variation, Review, Investigation, Suspension and Termination of Accreditation or Clinical Privileges.

Accreditation is Personal

99. Accreditation is personal and cannot be transferred to, or be excised by, any other person.

Basis of Accreditation

100. Accredited Practitioners may make a request for access to facilities for the treatment and care of their patients within the Delineation of Clinical Privileges granted and may utilise facilities provided by the Hospital for that purpose, subject to the provisions of these By-laws, resource limitations, and in accordance with Organisational Need and Organisational Capability.

101. The decision to grant access to facilities for the treatment and care of a patient is on each occasion within the sole discretion of the Chief Executive Officer and the grant of Accreditation contains no conferral of a general expectation with respect to future access to facilities or 'right of access'.

102. Accreditation does not of itself constitute an employment contract nor does it establish a contractual relationship between the Accredited Practitioner and the Hospital. It is a condition of accepting Accreditation, and of ongoing Accreditation, that the Accredited Practitioner understands and agrees that:

102.1 these By-Laws set out processes and procedures available to the Accredited Practitioner with respect to all matters relating to and impacting upon Accreditation;

102.2 no additional procedural fairness or natural justice principles will be incorporated or implied, other than processes and procedures that have been explicitly set out in these By-Laws;

102.3 the granting of Accreditation establishes only that the Accredited Practitioner is a person able to provide services at the Hospital, as well as the obligations and expectations with respect to the Accredited Practitioner while providing services at the Hospital for the period of Accreditation;

102.4 the granting of Accreditation creates no rights or legitimate expectation with respect to access to the Hospital or its resources;

102.5 while Healthe Care and the Hospital will generally conduct itself in accordance with the By-Laws, it is not bound to do so and there are no legal consequences for not doing so.

H. CONDITIONS OF ACCREDITATION AND CLINICAL RESPONSIBILITIES

103. Appointment (including continuing appointment) as an Accredited Practitioner shall be conditional upon the practitioner:

Compliance

(a) complying with the By-Laws, rules, policies, procedures, and codes of conduct of the Hospital and Healthe Care (as modified or amended from time to time);

(b) complying with the provisions of the Act, registration act, and any other relevant legislation regulating the practitioner and provision of health care in the particular State;

(c) complying with all applicable laws and associated Hospital policies and procedures, including in relation to workplace health and safety, anti-discrimination, bullying, harassment, aged care and working with children;

Admission, Attending Patients, Communication, and Discharge

(d) admitting and treating patients only within the Accreditation Category, Accreditation Type, Delineation of Clinical Privileges granted, including any terms or conditions attached to the approval of Accreditation;

(e) agreeing that if the Chief Executive Officer notifies the Accredited Practitioner upon Accreditation or Re-Accreditation, or at other times as determined by the Chief Executive Officer, of specified expectations in relation to exercising Accreditation and utilisation of the Hospital, then absent special circumstances the Accredited Practitioner must exercise Accreditation or utilise the Hospital facilities in accordance with the specified expectations;

(f) agreeing that admission of the Accredited Practitioner's patients to the Hospital is subject to bed availability, the availability or adequacy of nursing or allied health staff or facilities at the relevant Hospital given the type of treatment proposed to be conducted by the Accredited Practitioner;

(g) not admitting a patient to the Hospital until a provisional diagnosis or valid reason for admission has been stated, except in an emergency when a diagnosis or reasons for admission may be recorded as soon as practicable after admission;

(h) attending patients on a regular basis according to the clinical needs of the individual patients as would be judged appropriate by professional peers. If the Accredited Practitioner is unable to provide this level of care personally, he or she shall secure the agreement of another Accredited Practitioner to provide this level of care and treatment, and shall advise the Hospital of this arrangement;

(i) acknowledging that they are at all times responsible for the medical care of their patients and will therefore attend upon patients of the Accredited Practitioner in a timely manner when requested by Hospital staff or being available by telephone at all other times to assist Hospital staff in relation to the Accredited Practitioner's patients. Alternatively, the Accredited Practitioner will make arrangements with another Accredited Practitioner to assist or will put in place with prior notice appropriate arrangements in order for another Accredited Practitioner to assist in a timely manner, and will advise relevant staff of the Hospital of this arrangement;

(j) keeping the Hospital up to date about the Accredited Practitioner's current contact details and notifying promptly if contact details will change. Accredited Practitioners must ensure that their communication devices are functional and that appropriate alternative arrangements are in place to contact them if their communication devices need to be turned off for any reason;

(k) participating in formal on call arrangements as required by the Hospital following input from the Medical Advisory Committee;

(l) providing adequate instructions to, and supervision of, Hospital staff to enable staff to understand what care the Accredited Practitioner requires to be delivered to his or her patients. This includes giving such information to the Hospital as may

be necessary to ensure the protection of the patient from self harm and to ensure the protection of others (including staff, other patients and third parties) at the Hospital;

(m) acknowledging that they are required to work with and as part of a multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care for patients. Accredited Practitioners must at all times be aware of the importance of effective communication with other members of the health care team, referring doctors, the hospital executive, patients and the patient's family or next of kin, and at all times ensure appropriate communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to;

(n) noting the details of a transfer of care to another Accredited Practitioner on the patient's Hospital medical record and communicating the transfer to the Nurse Unit Manager or other responsible nursing staff member;

(o) ensuring the patient is not discharged without approval of the Accredited Practitioner (or their approved delegate), complying with the patient discharge policy of the Hospital, completing all patient discharge documents required by the Hospital, and ensuring all information and supports reasonably necessary to ensure continuity of care after discharge is provided to the referring practitioner, general practitioner and/or other treating practitioner, and where appropriate with the patient's carers/relatives. For a patient of a mental health facility with a requirement in place for approved leave from the Hospital, this includes the Accredited Practitioner providing adequate instructions to the Hospital staff, patient and patient's carers/relatives in relation to the leave;

(p) Not treating a member of their immediate family at the Hospital;

Surgery

(q) utilising as surgical assistants only those practitioners appointed in accordance with these By-Laws or who are in appropriate training positions at the Hospital;

(i) Accredited Practitioners are responsible for the conduct, performance and direct supervision of Surgical Assistants whilst performing procedures in the Hospital;

Medication Safety

(r) complying with all legal requirements and standards in relation to the prescription, administration, discard and safeguarding of medication, and properly documenting all drug orders clearly and legibly in the medication chart of the patient's Hospital medical record;

Medical Record Keeping

(s) taking all reasonable steps to ensure that adequate Hospital medical records are maintained for all patients under their care in accordance with statutory requirements, the Australian Council on Healthcare Standards requirements and as determined by the Hospital, including

(i) maintaining full, accurate, legible and contemporaneous medical records for all patients treated by him or her, including in relation to each attendance upon the patient, with the entries dated, timed and signed;

(ii) detailing all necessary information to enable the Hospital staff to provide necessary care and treatment to patients, including provision of pathology and radiology reports;

(iii) completing admission forms authorised by the Hospital within 24 hours of the admission of a patient;

(iv) recording an appropriate patient history, physical examination and treatment plan before treatment is undertaken, unless involving an emergency situation;

(v) completing an operation report that shall include a detailed account of the findings at surgery, the surgical technique undertaken, complications and post operative orders. Operative reports shall be written or dictated immediately and the report signed by the attending Accredited Practitioner and made part of the patient's Hospital medical record;

(vi) recording all orders for treatment legibly in the patient's Hospital medical record. Where necessary, a verbal order is acceptable as long as the Hospital policy and procedures is complied with in relation to a verbal order;

(vii) Where orders are given by telephone to a registered nurse (who will read back those orders to the Accredited Practitioner for confirmation), enter those orders in the medical record within twenty-four hours;

(viii) obtaining an anaesthetics consent if the Accredited Practitioner is performing anaesthetics, as well as maintaining a complete anaesthesia record to include evidence of pre-anaesthetic evaluation and post-anaesthetic follow-up of the patient's condition;

(ix) appropriately recording consultations to show documented evidence of a review of the patient, including any opinions or orders;

(x) ensuring inclusion of all relevant data reasonably required by the Hospital to enable it to meet health fund obligations, collect revenue and allow compilation of health care statistics, and that all Pharmaceutical Benefits Scheme prescription requirements and financial certificates are completed in accordance with the Hospital policy and regulatory requirements;

(xi) completing a discharge summary and providing all relevant information reasonably required by the referring practitioner, general practitioner or other treating practitioner for ongoing treatment of the patient and take all reasonable steps to ensure that, following the discharge of each patient, the Hospital’s medical record is completed within a reasonable time after the patient's discharge; and

(xii) acknowledges and agrees that medical records of patients of the Hospital are owned by the relevant Healthe Care entity operating the Hospital;

Consent

(t) Obtaining fully informed consent (except where it is not practical in cases of emergency), which will be documented, from the patient or their legal guardian or substituted decision maker prior to or on admission in accordance with accepted medical and legal standards and in accordance with the policy and procedures of the Hospital. For the purposes of these By-Laws, an emergency exists where immediate treatment is necessary in order to save a person's life or to prevent

serious injury to a person's health. It is expected that fully informed consent will be evidenced in writing and include an explanation of treatment and alternatives, informing the patient of material risks associated with treatment and alternatives, consent to treatment, appropriate consent in relation to privacy matters (including the collection, use and disclosure of health information for which consent is required), appropriate consent in relation to financial and billing matters for the Accredited Practitioner (including financial and billing matters relating to other Accredited Practitioners who may be called in for example to consult or provide anaesthetics), and other consents as required by law;

Notice of Leave

(u) an Accredited Practitioner must notify the Chief Executive Officer of the Hospital in writing, at least four weeks in advance of holidays and advise of Locum and / or coverage arrangements if applicable;

Quality Improvement, Risk Management and External Agency Involvement

(v) complying with all legal requirements in a timely manner in relation to the reporting of deaths to the Coroner;

(w) where requested by the Hospital, assisting with incident notification, management, investigation and reviews (including root cause analysis and other system reviews), and open disclosure processes, including by following the relevant Healthe Care or Hospital policies in relation to these matters;

(x) providing all reasonable and necessary assistance in circumstances where the Hospital requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction or an accreditation or health fund obligation, including responding to a court order, from a complaints commission, the police, Coroner, State or Commonwealth health department or other government agency;

(y) attending and participating in any committees, clinical quality assurance program, quality and safety initiatives, risk management activities and programs, continuing education program and training program approved by the Medical Advisory Committee. This includes to regularly attend and participate in clinical meetings, seminars, lectures and other training programmes as may be organised and held at the Hospital, as well as clinical audit and peer review activities, and to meet all reasonable requests to participate in education and training of medical and other professional nursing and technical staff of the Hospital, and in the education and training of students or junior staff attending the Hospital;

Conduct and Behaviour

(z) observing all requests made by the Hospital with regard to personal conduct in the Hospital and with regard to the provision of services within the Hospital;

(aa) conducting themselves in accordance with the code of ethics of the Australian Medical Association or other relevant code of ethics for the Accredited Practitioner as promulgated by their registration board, specialist college or professional body of which the Accredited Practitioner is a member, the code of practice of any specialist college or professional body of which the Accredited Practitioner is a member, and the code of conduct, behavioural policies and values of Healthe Care and the Hospital, including in relation to other Accredited Practitioners, hospital staff and executive, health care professionals, patients, family members or others;

(bb) not engaging in disruptive, aberrant or inappropriate behaviour, including arising from personal interactions with other Accredited Practitioners, hospital staff, health care professionals, patients, family members or others, and not engaging in behaviour which interferes or has the potential to interfere with the delivery of care or is disruptive or has the potential to be disruptive to the operations of the Hospital or management of its staff. Upon request by the Chief Executive Officer the Accredited Practitioner is required to meet with the Chief Executive Officer to discuss concerning behaviour or any other matters arising out of these By-Laws;

Research

(cc) agreeing that no research will be undertaken without the prior approval of an appropriate ethics committee and of the Chief Executive Officer. The activities to be undertaken in the research must fall within the Delineation of Clinical Privileges of the Accredited Practitioner;

(dd) agreeing that for aspects of the research falling outside an indemnity from a third party, the Accredited Practitioner must have in place adequate insurance with a reputable insurer to cover the medical research. Research will be conducted in accordance with the National Health and Medical Research Council requirements, National Statement on Ethical Conduct in Human Research and other applicable legislation. An Accredited Practitioner has no power to bind Healthe Care to a research project by executing a research agreement;

New Service, Intervention, Procedure or Technology

(ee) seeking prior approval of the Chief Executive Officer (who will consult with the Director of Medical Services (if appointed), Director of Clinical Services and Medical Advisory Committee) through use of the approved application material and complying with the relevant policy, in regard to any substantially new or substantially amended service, intervention, procedure, or technology to treat patients, or any new or amended service, intervention, procedure, or use of technology to treat patients which may increase the risk to patients, as well as providing evidence of adequate professional indemnity insurance and if requested evidence that private health funds will adequately fund the service;

(ff) complying with the requirements of the Policy for the Safe Introduction of New Interventional Procedures into Clinical Practice;

(gg) providing progress reports in the approved form in relation to the new or amended service, intervention, procedure, or technology, at intervals determined by the Chief Executive Officer, and complying with any further directions in relation to the new or amended service, intervention, procedure, or technology;

Insurance and Registration

(hh) maintaining an adequate level of professional indemnity membership and/or insurance with an approved medical indemnity organisation or insurer and covering the Clinical Privileges granted. The determination of what is an adequate level of insurance cover will be as determined by the Chief Executive Officer, but will include insurance, including run off / tail insurance, to cover all potential liability of the Accredited Practitioner, that is with a reputable insurance company acceptable to the Chief Executive Officer and is in an amount and on terms that the Chief Executive Officer in his or her absolute discretion considers to be sufficient;

(ii) maintaining registration with their relevant health registration board;

(jj) furnishing annually (or at other times upon request) to the Hospital documentary evidence of professional indemnity membership and/or insurance including the level of cover and any material changes to cover that occurred during the last 12 months, and furnishing annually (or at other times upon request) to the Hospital documentary evidence of medical registration under the registration act regulating medical practitioners in the State;

Notifications and Continuous Disclosure

(kk) advising the Chief Executive Officer as soon as possible, and following up in writing no later than 2 days of the occurrence, should:

(i) an investigation be commenced in relation to the Accredited Practitioner, or about his/her patient (irrespective of whether this relates to a patient of the Hospital) by the Accredited Practitioner's registration board, disciplinary body, Coroner, health complaints body, or another statutory authority; or

(ii) an adverse finding be made against him/her by the relevant registration board or disciplinary body, a civil court, Coroner, health complaints body, or another statutory authority, irrespective of whether this relates to a patient of the Hospital; or

(iii) his/her professional registration be revoked or amended, or should conditions be imposed, or should undertakings be agreed, irrespective of whether this relates to a patient of the Hospital and irrespective of whether this is noted on the public register or is privately agreed with a registration board; or

(iv) professional indemnity membership be made conditional or not be renewed, or should limitations be placed on insurance or professional indemnity coverage; or

(v) his/her appointment or Clinical Privileges or Delineation of Clinical Privileges at any other facility, hospital or day procedure centre alter in any way, including if it is withdrawn, terminated, suspended, restricted or made conditional, irrespective of whether this is unilaterally imposed by the hospital or done by way of agreement with the Accredited Practitioner, or should an investigation be commenced or concluded by another facility, hospital or day procedure centre at which the Accredited Practitioner holds Clinical Privileges and the investigation is connected to or relates in some way to the performance of services falling within the Clinical Privileges;

(vi) the practitioner be investigated, charged with having committed, or is convicted of a sex or violence or other serious criminal offence. The Accredited Practitioner must provide authority to the Hospital, upon request, to conduct a criminal history check with the appropriate authorities; or

(vii) any physical or mental condition or substance abuse problem occur that could affect his or her ability to practise or that would require any special assistance or support to enable him or her to practise safely and competently.

(ll) keeping the Chief Executive Officer continuously informed of every fact and circumstance which has, or will likely have, a material bearing upon:

(i) matters listed in By-Law 103(kk);

(ii) the Accreditation of the Accredited Practitioner;

(iii) the Delineation of Clinical Privileges of the Accredited Practitioner;

(iv) the ability of the Accredited Practitioner to safely deliver health care services to his or her patients within the Delineation of Clinical Privileges;

(v) the Accredited Practitioner's registration or professional indemnity insurance arrangements;

(vi) the inability of the Accredited Practitioner to satisfy a medical malpractice claim by a patient;

(vii) the reputation of the Accredited Practitioner as it relates to the provision of clinical care at the Hospital or to specific patients at the Hospital;

(viii) adverse outcomes or complications in relation to the Accredited Practitioner's patients at the Hospital (current or former); and

(ix) the reputation of the Hospital and Healthe Care.

Subject to restrictions imposed by legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the Chief Executive Officer informed and updated about the commencement, progress and outcome of compensation claims, coronial investigations or inquests, police investigations, complaint body investigations or other inquiries involving patients of the Accredited Practitioner that were treated at the Hospital.

Representations and Media

(mm) not representing in any way that the Accredited Practitioner represents a member of the Healthe Care Group or the Hospital in any circumstances, including in relation to the use of Hospital letterhead, unless with the express written permission of the Chief Executive Officer;

(nn) not, without prior written consent of the Chief Executive Officer, communicating or interacting with the media regarding any matter involving Healthe Care, the Hospital or a Hospital patient.

Notifiable Conduct and Mandatory Reporting

(oo) All Accredited Practitioners must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the Health Practitioner Regulation National Law Act 2009, as in force in each state and territory.

104. Healthe Care believes that national clinical guidelines and standards developed collaboratively by organisations such as:

(a) Australian Commission on Safety and Quality in Health Care;

(b) National Health and Medical Research Organisation;

(c) National Institute of Clinical Studies;

(d) Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIPS);

(e) recognised authorities in evidence based medicine, such as the Cochrane Collaboration;

(f) specialist training colleges and organisation accredited by the Australian Medical Council;

(g) the clinical professional organisations and societies; and

(h) various peak clinical non-government organisations (such as the National Heart Foundation, Diabetes Australia, National Stroke Foundation, Australian Kidney Health, Asthma Foundation, Cancer Foundation)

represent the current clinical 'best practice' for many areas of medicine, and should whenever possible and practicable, be consulted for guidance to support informed clinical decision-making and the development of pathways of care that yield optimal clinical outcomes. While all clinical decisions are, ultimately, the prerogative of the treating Accredited Practitioner, Healthe Care encourages the use of evidence-based clinical guidelines and medicine at its Hospitals unless the particular clinical circumstances of a patient requires otherwise.

I. VARIATION, REVIEW, TRANSFER, SUSPENSION AND TERMINATION OF ACCREDITATION OR CLINICAL PRIVILEGES

Variation of Clinical Privileges

105. An Accredited Practitioner may at any time make application for variation of his or her Clinical Privileges.

106. The processes for variation of Accreditation are the same as for an initial application for Accreditation. However, the Chief Executive Officer may waive the requirement for the Accredited Practitioner to submit an application form if the Chief Executive Officer is satisfied that there has been no significant change to any relevant information provided to the Hospital since the date on which the Accredited Practitioner last received Accreditation.

107. The Chief Executive Officer shall cause any such application to be forwarded to the Credentials and Clinical Privileges Committee.

108. The Credentials and Clinical Privileges Committee shall give the application appropriate consideration and make a recommendation to the Medical Advisory Committee as to the variation sought.

109. The Medical Advisory Committee shall review the recommendation of the Credentials and Clinical Privileges Committee and make its own recommendation to the Chief Executive Officer as to the variation sought.

110. The Chief Executive Officer will consider the recommendation from the Medical Advisory Committee concerning the application, shall reach his or her decision, and shall within seven days notify the Accredited Practitioner of the decision.

111. The Chief Executive Officer may also direct that an application for variation of Accreditation be made by an Accredited Practitioner if the current Clinical Privileges granted do not support the care or treatment sought to be undertaken by the Accredited Practitioner.

Review of Accreditation or Clinical Privileges

112. The Chief Executive Office may at any time initiate a review, including arising out of the periodic performance review process, of an Accredited Practitioner's Accreditation or Clinical Privileges where concerns or an allegation are raised about any of the following:

(a) Patient health or safety could potentially be compromised or at risk;

(b) The rights or interests of a Patient, staff or someone engaged in or at the Hospital has been adversely affected or could be infringed upon or arising from a behavioural concern;

(c) A breach of the law could have been committed;

(d) The Accredited Practitioner's Competence;

(e) The Accredited Practitioner's Current Fitness;

(f) The Accredited Practitioner's Performance;

(g) Compatibility with Organisational Capability and Organisational Need;

(h) Confidence in the Accredited Practitioner;

(i) Compliance with these By-Laws, including terms and conditions, or a possible ground for suspension or termination of Accreditation may have occurred;

(j) The efficient operation of the Hospital could be threatened or disrupted, the potential loss of the Hospital's licence or accreditation, a potential breach of a health fund agreement or the potential to bring the Hospital into disrepute;

(k) The current Clinical Privileges granted do not support the care or treatment sought to be undertaken by the Accredited Practitioner; or

(l) As elsewhere defined in these By-Laws.

113. The Chief Executive Officer will determine whether the process to be followed is an:

(a) Internal review; or

(b) External review.

114. Prior to determining whether an internal review or external review will be conducted, the Chief Executive Officer may in his or her absolute discretion meet with the Accredited Practitioner, along with any other persons the Chief Executive Officer considers appropriate, advise of the concern or allegation raised, and invite a preliminary response from the Accredited Practitioner (in writing or orally as determined by the Chief Executive Officer) before the Chief Executive Officer makes a determination whether a review will proceed, and if so, the type of review.

115. The review may have wider terms of reference than a review of the Accreditation or Clinical Privileges.

116. The Chief Executive Officer must make a determination whether to impose an interim suspension or conditions upon Accreditation pending the outcome of the review in accordance with the relevant By-laws dealing with interim suspension and conditions,

save that there shall be no right of appeal with respect to the imposition of an interim suspension or conditions.

117. In addition, or as an alternative, to conducting an internal or external review, the Chief Executive Officer will notify the Accredited Practitioner's registration board and/or other professional body responsible for the Accredited Practitioner of details of the concerns raised if required by legislation, the Chief Executive Officer considers it is in the interests of patient care or safety to do so, it is in the interests of protection of the public, or it is considered that the registration board or professional body is more appropriate to investigate and take necessary action. Following the outcome of any action taken by the registration board and/or other professional body the Chief Executive Officer may elect to take action, or further action, under these By-Laws.

Internal Review of Accreditation or Clinical Privileges

118. The Chief Executive Officer will establish the terms of reference of the Internal Review, and may seek assistance of an employee of the Hospital, a member or members of the Medical Advisory Committee, co-opted Accredited Practitioners or representatives from within Healthe Care who bring specific expertise to the internal review as determined by the Chief Executive Officer.

119. The terms of reference, process, and reviewers will be as determined by the Chief Executive Officer. The process will ordinarily include providing to the Accredited Practitioner reasonable particulars about issues of concern, the potential outcomes of the review, the opportunity for submissions from the Accredited Practitioner (which may be written and/or verbal as determined by the Chief Executive Officer), and provision of a copy of these By-Laws. Access to additional information or documents will be at the complete discretion of the Chief Executive Officer

120. The Chief Executive Officer will notify the Accredited Practitioner in writing of the review, the terms of reference, process and reviewers.

121. A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewers to the Chief Executive Officer.

122. Following consideration of the report, the Chief Executive Officer is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate the Accreditation. Prior to making a decision, the Chief Executive Officer may elect to provide the Accredited Practitioner with a copy of the report or a reasonable summary of the issues of concern and relevant findings, meet with the Accredited Practitioner or invite a submission, before the Chief Executive Officer makes a decision.

123. The Chief Executive Officer must notify the Accredited Practitioner in writing of the determination made, the reasons for it, and advise of the right of appeal (if any), the appeal process and the timeframe for an appeal.

124. The Accredited Practitioner shall have the rights of appeal established by these By-Laws in relation to the final determination made by the Chief Executive Officer if a decision is made to amend, suspend, terminate or impose conditions on the Accreditation.

125. In addition or as an alternative to taking action in relation to the Accreditation following receipt of the report, the Chief Executive Officer will notify the Accredited Practitioner's registration board and/or other professional body responsible for the Accredited Practitioner of details of the concerns raised and outcome of the review if required by legislation, the Chief Executive Officer considers it is in the interests of patient care or safety to do so, it is in the interests of protection of the public, it is considered appropriate

that the registration board or professional body consider the matter, or it should be done to protect the interests of the Hospital or Healthe Care.

External Review of Accreditation or Clinical Privileges

126. The Chief Executive Officer will make a determination about whether an external review will be undertaken.

127. An external review will be undertaken by a person or persons external to Healthe Care, the Hospital and of the Accredited Practitioner in question and such person(s) will be nominated by the Chief Executive Officer at his or her discretion.

128. The terms of reference, process, and reviewers will be as determined by the Chief Executive Officer. The process will ordinarily include providing to the Accredited Practitioner reasonable particulars about issues of concern, the potential outcomes of the review, the opportunity for submissions from the Accredited Practitioner (which may be written and/or verbal as determined by the Chief Executive Officer), and provision of a copy of these By-Laws. Access to additional information or documents will be at the complete discretion of the Chief Executive Officer

129. The Chief Executive Officer will notify the Accredited Practitioner in writing of the review, the terms of reference, process and reviewers.

130. The external reviewer(s) is required to provide a detailed report on the findings of the review in accordance with the terms of reference to the Chief Executive Officer.

131. The Chief Executive Officer will review the report and make a determination of whether to continue (including with conditions), amend, suspend or terminate the Accreditation.

132. The Chief Executive Officer must notify the Accredited Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal (if any), the appeal process and the timeframe for an appeal. Prior to making a decision, the Chief Executive Officer may elect to provide the Accredited Practitioner with a copy of the report or a reasonable summary of the issues of concern and relevant findings, meet with the Accredited Practitioner or invite a submission, before the Chief Executive Officer makes a decision.

133. The Accredited Practitioner shall have the rights of appeal established by these By-Laws in relation to the final determination made by the Chief Executive Officer if a decision is made to amend, suspend, terminate or impose conditions on the Accreditation.

134. In addition or as an alternative to taking action in relation to the Accreditation following receipt of the report, the Chief Executive Officer will notify the Accredited Practitioner's registration board and/or other professional body responsible for the Accredited Practitioner of details of the concerns raised and outcome of the review if required by legislation, the Chief Executive Officer considers it is in the interests of patient care or safety to do so, it is in the interests of protection of the public, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of the Hospital or Healthe Care.

Transfer of Accreditation Status Between Facilities

135. An Accredited Practitioner who is Accredited at a specified Healthe Care Hospital may apply in writing to the Chief Executive Officer of another Healthe Care Hospital for the Accreditation to be extended to that Hospital;

136. Applications and accompanying documentation from the original Healthe Care Hospital in which the Accreditation was approved will be submitted to the Credentialing and Clinical Privileges Committee or such other Committee as the Hospital determines, of the new Healthe Care Hospital for endorsement prior to the approval by the Chief Executive Officer;

137. Transferral of Accreditation status is not automatic, and the decision makers involved must still satisfy themselves as to the training, experience, competence, judgement, professional capabilities and knowledge, Current Fitness, Credentials, character of the applicant, Organisational Need and Organisational Capabilities.

138. A transferral of Accreditation status can only be on the basis of the same or lesser Accreditation held at the original Healthe Care Hospital (including Accreditation Category, Type, Level and Delineation of Clinical Privileges), otherwise an application must be made for an initial Accreditation;

139. There will be no right of appeal in respect of the decision not to transfer Accreditation status between the Healthe Care Hospitals.

Suspension of Clinical Privileges

140. The Chief Executive Officer may suspend the Clinical Privileges of an Accredited Practitioner should the Chief Executive Officer believe any of the following apply:

(a) it is in the interests of patient care or safety. This can be based upon an investigation by an external agency including a registration board, disciplinary body, Coroner, complaints commission or another health service, and may be related to a patient or patients at another facility not operated by the Hospital;

(b) the continuance of the current Clinical Privileges raises a concern about the safety and quality of health care to be provided by the Accredited Practitioner;

(c) it is in the interests of staff welfare, staff safety or workplace health and safety, including with respect to behavioural concerns;

(d) serious and unresolved allegations have been made in relation to the Accredited Practitioner. This may be related to a patient or patients of another facility not operated by the Hospital, including if these are the subject of review by an external agency including a registration board, disciplinary body, Coroner, complaints commission or another health service;

(e) the Accredited Practitioner has failed to observe any of the terms and conditions of Accreditation;

(f) the behaviour or conduct is in breach of a direction or undertaking, these By-laws, or a conduct of conduct, policy or procedure of the Hospital or Healthe Care;

(g) the behaviour or conduct is such that it is unduly hindering the efficient operation of the Hospital at any time, or is bringing the Hospital or Healthe Care into disrepute;

(h) the behaviour or conduct is inconsistent with a policy, procedure, direction or code of conduct in relation to the expected standard of behaviour or conduct at the Hospital;

(i) the behaviour or conduct is inconsistent with the values of Healthe Care or the Hospital;

(j) the Accredited Practitioner has been suspended by their registration board or disciplinary body;

(k) there is a finding of professional misconduct, unprofessional conduct, unsatisfactory conduct or some other adverse professional finding (however described) by a registration board or other relevant disciplinary body or professional standards organisation for the Accredited Practitioner;

(l) the Accredited Practitioner's professional registration is amended, or conditions imposed, or undertakings agreed, irrespective of whether this relates to a current or former patient of the Hospital;

(m) the Accredited Practitioner has made a false declaration or provided false or inaccurate information to the Hospital, including through omission of important information, inclusion of false or inaccurate information or a failure to update with new information (including in the application for Accreditation or re-accreditation);

(n) the Accredited Practitioner fails to make the notifications required to be given pursuant to these By-laws or based upon the information contained in a notification suspension is considered appropriate;

(o) the Accreditation, Clinical Privileges or Delineation of Clinical Privileges have been suspended, terminated, restricted or made conditional by another health care organisation;

(p) the Accredited Practitioner is the subject of a criminal investigation about a serious matter (for example a drug related matter, or an allegation of a crime against a person such as a sex or violence offence) which, if established, could affect his or her ability to exercise his or her Clinical Privileges safely and competently and with the confidence of the Hospital and the broader community;

(q) the Accredited Practitioner has been convicted of a crime which could affect his or her ability to exercise his or her Clinical Privileges safely and competently and with the confidence of the Hospital and the broader community;

(r) based upon a finalised Internal Review or External Review pursuant to these By-laws any of the above criteria for suspension are considered to apply;

(s) an Internal Review or External Review has been initiated pursuant to these By-laws and the Chief Executive Officer considers that an interim suspension is appropriate pending the outcome of the review; or

(t) there are other unresolved issues or concerns in respect of the Accredited Practitioner that the Chief Executive Officer considers is a ground for suspension.

141. The Chief Executive Officer must notify the Accredited Practitioner in writing of:

(a) the fact of the suspension;

(b) the period of suspension;

(c) the reasons for suspension;

(d) if the Chief Executive Officer considers it applicable and appropriate in the circumstances, invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider the suspension should be lifted;

(e) if the Chief Executive Officer considers it applicable and appropriate in the circumstances, advise the Accredited Practitioner of any actions that must be performed for the suspension to be lifted and the period within which those actions must be completed; and

(f) The right of appeal, the appeal process and the time frame for an appeal.

142. As an alternative to an immediate suspension, the Chief Executive Officer may elect to deliver a show cause notice to the Accredited Practitioner advising of:

(a) the facts and circumstances forming the basis for possible suspension;

(b) the grounds under the By-laws upon which suspension may occur;

(c) invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider suspension is not appropriate;

(d) if applicable and appropriate in the circumstances, any actions that must be performed for the suspension not to occur and the period within which these actions must be completed; and

(e) a timeframe in which a response is required from the Accredited Practitioner to the show cause notice.

Following receipt of the response the Chief Executive Officer will determine whether the Accreditation will be suspended. If suspension is to occur notification will be sent in accordance with the notification requirements of this By-law. Otherwise, the Accredited Practitioner will be advised that suspension will not occur at this stage, however this will not prevent the Chief Executive Officer from taking other action at this time, including imposition of conditions, and will not prevent the Chief Executive Officer from relying upon these matters as a ground for suspension or termination in the future.

143. The suspension of Accreditation is ended either by terminating the Accreditation or lifting the suspension. This will occur by a written notification from the Chief Executive Officer.

144. The resumption of Accreditation by a previously suspended Accredited Practitioner is subject to the Accredited Professional observing the requirements for continuous disclosure contained in these By-Laws.

145. Ordinarily suspension will be a suspension of the Clinical Privileges in their entirety, however the Chief Executive Office may determine for a particular case that the suspension will be a specified part of the Clinical Privileges only and these By-Laws in relation to suspension will apply to the specified part of the Clinical Privileges that are suspended.

146. The affected Accredited Practitioner shall have the rights of appeal established by these By-Laws.

147. If there is held, in good faith, a belief that matters forming the grounds for suspension give rise to a significant concern about the safety and quality of health care provided by the Accredited Practitioner including but not limited to patients outside of the Hospital, it is in the interests of patient care or safety to do so, it is in the interest of protection of the public to do so, it is required by legislation or for other reasonable grounds, the Chief Executive Officer will notify the Accredited Practitioner's registration board and/or other relevant regulatory agency of the suspension and the reasons for it.

Termination of Accreditation

148. Accreditation will immediate terminate:

(a) if the Accredited Practitioner ceases to be registered pursuant to the relevant registration act for the Accredited Practitioner;

(b) if the Accredited Practitioner ceases to maintain an adequate level of professional indemnity membership and/or insurance with an approved medical indemnity organisation or insurer covering the Clinical Privileges granted. The determination of what is an adequate level of insurance cover will be as determined by the Chief Executive Officer, but will include insurance, including run off / tail insurance, to cover all potential liability of the Accredited Practitioner, that is with a reputable insurance company acceptable to the Chief Executive Officer and is in an amount and on terms that the Chief Executive Officer in his or her absolute discretion considers to be sufficient;

(c) if the Accredited Practitioner also holds a written contract of employment or to provide services which is terminated or ends, and is not renewed; or

(d) if a term or condition that attaches to an approval of Accreditation is breached, not satisfied, or according to that term or condition results in the Accreditation concluding.

149. Accreditation may be terminated by the Chief Executive Officer, should the Chief Executive Officer believe any of the following apply:

(a) based upon any of the matters listed as a ground for suspension and it is considered by the Chief Executive Officer that suspension is an insufficient response in the circumstances;

(b) based upon a finalised Internal Review or External Review and termination of Accreditation is considered appropriate in the circumstances or in circumstances where the Chief Executive Officer does not have confidence in the continued appointment of the Accredited Practitioner;

(c) the Accredited Practitioner is not regarded by the Chief Executive Officer as having the appropriate Current Fitness to retain Accreditation, or the Chief Executive Officer does not have confidence in the continued appointment of the Accredited Practitioner;

(d) conditions have been imposed by the Accredited Practitioner's registration board that restricts practice and the Hospital does not have capacity or adequate ability or resources, or is not willing to allocate the extra resources to meet the conditions imposed;

(e) the Accredited Practitioner has not exercised Accreditation or utilised the facilities of the Hospital for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Accredited Practitioner by the Chief Executive Officer;

(f) the Clinical Privileges or Delineation of Clinical Privileges is no longer supported by Organisational Capability or Organisational Need;

(g) the Accredited Practitioner becomes permanently incapable of performing his/her duties which shall for the purposes of these By-laws be a continuous period of 6 months' incapacity; or

(h) there are other issues or concerns in respect of the Accredited Practitioner that is considered to be a ground for termination.

150. The appointment of an Accredited Practitioner may be terminated as otherwise provided in these By-Laws.

151. The Chief Executive Officer must notify the Accredited Practitioner in writing of:

(a) the fact of the termination;

(b) the reasons for the termination;

(c) if the Chief Executive Officer considers it applicable and appropriate in the circumstances, invite a written response from the Accredited practitioner, including a response why the Accredited Practitioner may consider a termination should not have occurred; and

(d) if a right of appeal is available in the circumstances, the right of appeal, the appeal process and the time frame for an appeal.

152. As an alternative to an immediate termination, the Chief Executive Officer may elect to deliver a show cause notice to the Accredited Practitioner advising of:

(a) the facts and circumstances forming the basis for possible termination;

(b) the grounds under the By-laws upon which termination may occur;

(c) invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider termination is not appropriate;

(d) if applicable and appropriate in the circumstances, any actions that must be performed for the termination not to occur and the period within which these actions must be completed; and

(e) a timeframe in which a response is required from the Accredited Practitioner to the show cause notice.

Following receipt of the response the Chief Executive Officer will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with the notification requirements of this By-law. Otherwise, the Accredited Practitioner will be advised that termination will not occur at this stage, however this will not prevent the Chief Executive Officer from taking other action at this time, including imposition of conditions, and will not prevent the Chief Executive Officer from relying upon these matters as a ground for suspension or termination in the future.

153. For a termination pursuant to By-Law 148, namely immediate termination, there shall be no right of appeal.

154. For a termination pursuant to By-Law 149, namely termination within the discretion of the Chief Executive Officer, the Accredited Practitioner shall have the rights of appeal established by these By-Laws.

155. Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by the Chief Executive Officer to the Accredited Practitioner's registration board and/or other relevant regulatory agency.

Imposition of Conditions

156. At the conclusion of or pending finalisation of an Internal or External Review pursuant to these By-Laws, or in lieu of the suspension of Clinical Privileges or termination of Accreditation, the Chief Executive Officer may elect to impose conditions on the Accreditation or exercise of Clinical Privileges.

157. The imposition of conditions may be recommended by the Credentials and Clinical Privileges Committee or Medical Advisory Committee, but is in the ultimate discretion of the Chief Executive Officer.

158. The Chief Executive Officer must notify the Accredited Practitioner in writing of the imposition of conditions, the reasons for it, the consequences if the conditions are breached, and advise of the right of appeal, the appeal process and the timeframe for an appeal.

159. If the Chief Executive Officer considers it applicable and appropriate in the circumstances, they may also invite a written response from the Accredited Practitioner as to why the Accredited Practitioner may consider the conditions should not be imposed.

160. If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Chief Executive Officer.

161. The appeal procedure contained in these By-Laws will apply to an imposition of conditions.

162. If there is held, in good faith, a belief that the continuation of the unconditional right to practise in any other organisation would raise a significant concern about the safety and quality of health care for patients and the public, the Chief Executive Officer will notify the Accredited Practitioner's registration board and/or other relevant regulatory agency of the imposition of the conditions and the reasons the conditions were imposed.

Notification to other Healthe Care Facilities

163. The decision to suspend Clinical Privileges and any other relevant information will be notified by the Chief Executive Officer to other Healthe Care facilities where the Accredited Practitioner is Accredited, as well as notification subsequently whether an appeal has been lodged. The Chief Executive Officer of that other Healthe Care facility may, based upon this information, elect to immediately suspend Clinical Privileges or may ask the Accredited Practitioner to show cause why a suspension or other action should not occur at their facility.

164. The decision to terminate Accreditation and any other relevant information will be notified by the Chief Executive Officer to the other Healthe Care facilities where the Accredited Practitioner is Accredited, as well as notification whether an appeal has been lodged (if an appeal is available in the circumstances). Unless the Chief Executive Officer decides otherwise in the circumstances of a particular case, the termination of Accreditation at one Healthe Care facility will result in automatic termination of Accreditation at all other Healthe Care facilities where the Accredited Practitioner holds Accreditation. If an automatic termination of Accreditation has not occurred as determined by the Chief Executive Officer, the Chief Executive Officer of that other Healthe Care facility may elect, based upon this information, to ask the Accredited Practitioner to show cause why a termination or other action should not occur at their facility.

165. The decision to impose conditions and any other relevant information will be notified by the Chief Executive Officer to other Healthe Care facilities where the Accredited Practitioner is Accredited, as well as notification subsequently whether an appeal has

been lodged. The Chief Executive Officer of that other Healthe Care facility may, based upon this information, elect to immediately impose the same condition or may elect to ask the Accredited Practitioner to show cause why the imposition of conditions or other action should not occur at their facility.

Resignation and Expiration of Accreditation

166. An Accredited Practitioner may resign his/her Accreditation after the expiry of one month after the giving of notice to the Chief Executive Officer, unless a shorter timeframe is otherwise agreed by the Chief Executive Officer.

167. An Accredited Practitioner who intends to cease treating patients either indefinitely or for an extended period must notify his or her intention to the Chief Executive Officer. Accreditation will be taken to be withdrawn one month from the date of notification unless the Chief Executive Officer decides a shorter notice period is appropriate in the circumstances.

168. If an application for Re-Accreditation is not received within the timeframe provided for in these By-Laws, unless determined otherwise by the Chief Executive Officer, the Accreditation will expire at the conclusion of its term. If the Accredited Practitioner wishes to admit or treat patients at the Hospital after the expiration of Accreditation, an application for Accreditation must be made as an application for initial Accreditation.

169. If the Accredited Practitioner's Clinical Privileges are no longer supported by Organisational Capability or Organisational Need, if the Accredited Practitioner will no longer be able to meet the terms and conditions of Accreditation, or where admission of patients or utilisation of services at the Hospital is regarded by the Chief Executive Officer to be insufficient, the Chief Executive Officer may raise these matters in writing with the Accredited Practitioner and invite a meeting to discuss, following which the Chief Executive Officer and Accredited Practitioner may agree that Accreditation will expire and they will agree on the date for expiration of Accreditation. Following the date of expiration, if the Accredited Practitioner wishes to admit or treat patients at the Hospital, an application for Accreditation must be made as an application for initial Accreditation.

170. The provisions in relation to resignation and expiration of Accreditation in no way limit the ability of the Chief Executive Officer to take action pursuant to other provisions of these By-Laws, including by way of suspension or termination of Accreditation.

171. An Accredited Practitioner must, whenever practicable, advise the Chief Executive Officer prior to the cessation of their normal patient bookings and clinical activities. The Accredited Practitioner must ensure that upon cessation, any remaining patients are either discharged or referred with appropriate consent to the care of another equivalent Accredited Practitioner to ensure continuous cover. It is the responsibility of the Accredited Practitioner to advise his or her own patients, and any known carers or legal guardians of their patients, of any proposed changes to the care arrangements.

Appeal Procedure

172. An Accredited Practitioner shall have the rights of appeal as set out in these By-Laws.

173. An Accredited Practitioner shall have fourteen days from the date of the letter providing notification of a decision to which there is a right of appeal to lodge an appeal against the decision.

174. An appeal by the Accredited Practitioner must be made in writing to the Chief Executive Officer and received by the Chief Executive Officer within the fourteen day appeal period or else the right to appeal is lost.

175. Unless decided otherwise by the Chief Executive Officer in the circumstances of the particular case, which will only be in exceptional circumstances, lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand.

176. The Chief Executive Officer shall establish a Committee ("the Appeal Committee") to hear the appeal.

177. The Appeal Committee shall comprise at least three persons, including the following members:

    (a) a nominee of the Chief Executive Officer, who may be an Accredited Practitioner;

    (b) a nominee of the Chief Executive Officer of Healthe Care, who may be an Accredited Practitioner;

    (c) a nominee of the chairperson of the Medical Advisory Committee, who may be an Accredited Practitioner; and who will ordinarily be a member of the appropriate professional college or body of the appellant.

178. Proposed members of the Appeal Committee before accepting the appointment will confirm that they do not have a conflict of interest relating to the appellant that would impact upon their involvement in hearing the appeal and will agree to sign a confidentiality agreement in relation to the matters the subject of the appeal.

179. Any other member of the Appeal Committee will be appointed by, and is at the discretion of, the Chief Executive Officer.

180. The chairperson of the Appeal Committee shall be nominated by and will be one of the appointed nominees of the Chief Executive Officer.

181. The Chief Executive Officer will establish the terms of reference and submit all relevant material to the chairperson of the Appeal Committee.

182. Unless a shorter timeframe is agreed by the appellant and the Appeal Committee, the appellant shall be provided with 7 days notice of the date for determination by the Appeal Committee. The notice from the Appeal Committee will ordinarily set out the allegations or concerns, the date for the determination of the appeal, the members of the Appeal Committee, the process that will be adopted, will invite the appellant to make a submission, and subject to an agreement to maintain confidentiality will provide copies of material to be relied upon by the Appeal Committee.

183. The appellant will be given the opportunity to make a submission to the Appeal Committee. The Appeal Committee shall determine whether the submission by the appellant may be in writing or in person or both.

184. If the appellant elects to provide written submissions to the Appeal Committee, following such a request from the Appeal Committee for a written submission, unless a longer time frame is agreed between the Appellant and Appeal Committee the written submissions will be provided within 7 days of request.

185. If the Appeal Committee agrees that the appellant may attend a meeting of the Appeal Committee, including to answers questions of the Appeal Committee or to make an address to the Appeal Committee, the appellant is not entitled to have formal legal representation at the meeting of the Appeal Committee. The appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the Appeal Committee.

186. The Chief Executive Officer (or nominee) may make submissions to the Appeal Committee in order to support the decision under appeal.

187. The chairperson of the Appeal Committee shall determine any question of procedure for the Appeal Committee, including at any meeting, with questions of procedure entirely within the discretion of the chairperson of the Appeal Committee.

188. The appellant shall not be present during Appeal Committee deliberations except when invited to be heard in respect of his/her appeal.

189. The Appeal Committee shall make a written recommendation and provide reasons for the recommendation, which recommendation may be made by a majority of the members of the Appeal Committee (and if an even number of Appeal Committee members, the chairperson has the deciding vote), to the Chief Executive Officer of Healthe Care who shall consider such a recommendation and make a decision about the appeal.

190. The decision of the Chief Executive Officer of Healthe Care will be notified in writing to the appellant.

191. The decision of the Chief Executive Officer of Healthe Care shall be final and binding and there are no appeals permitted under these By-Laws from this decision.

192. If a notification has already been given to an external agency, such as a registration board, the Chief Executive Officer will notify that external agency of the appeal decision. If a notification has not already been given, the Chief Executive Officer will make a determination whether notification should now occur based upon the relevant considerations for notification to an external agency as set out in these By-Laws relating to the decision under appeal.

Conflict of Interest

193. Other than the Chief Executive Officer, persons involved in making a decision about the Accreditation or Clinical Privileges in this section of the By-Laws should immediately notify the Chief Executive Officer of an actual or potential conflict of interest, or a commercial competitive relationship, with the Accredited Practitioner.

J. PATIENT CARE REVIEW COMMITTEE

Patient Care Review Committee

194. The Patient Care Review Committee (if established at a particular Hospital), a sub-committee of the Medical Advisory Committee which reports to the Medical Advisory Committee, shall:

(a) oversee the development and maintenance of an adequate patient care review and patient safety and quality improvement program in liaison with relevant representatives of the Hospital for an ensuing 12 month period;

(b) oversee, review and make recommendations in relation to patient safety and quality initiatives;

(c) oversee, review and make recommendations in relation to clinical indicators and outcomes aimed at improvements in patient safety and quality;

(d) review unplanned transfers in and out of the Hospital, unplanned transfers in and out of special care units, returns to theatre, sentinel events, and patient deaths;

(e) ensure the patient care review monitoring and assessment activities are appropriate to the Hospital;

(f) ensure the Hospital safety and quality improvement activities satisfy applicable quality assurance statutory requirements and standards;

(g) review and make recommendations in relation to reports on patient care review and quality improvement activities undertaken;

(h) review and make recommendations in relation to the actions taken regarding the patient care review and quality improvement activities undertaken; and

(i) make recommendations to the Medical Advisory Committee regarding ongoing management of patient care review and quality improvement at the Hospital.

Membership of Patient Care Review Committee

195. Membership of the Patient Care Review Committee shall at a minimum comprise:

(a) Two representatives from the Medical Advisory Committee (elected on an annual basis);

(b) A representative Accredited Practitioner from each major specialty group of the Hospital;

(c) The Chief Executive Officer and Director of Clinical Services (or their delegates);

(d) Other relevant persons who may be co-opted as determined by the committee.

196. With agreement from the Chief Executive Officer and Medical Advisory Council, sub-committees of the Patient Care Review Committee may be formed to deal with specific matters or issues or areas of speciality. The Chief Executive Office and Director of Clinical Services (or their delegates) must be included as members of each sub-committee.

Chairperson of Patient Care Review Committee

197. The chairperson of the Patient Care Review Committee shall be elected for an annual term from the Accredited Practitioner members of the committee.

Meetings of Patient Care Review Committee

198. Meetings of the Patient Care Review Committee shall be held no less than four times per year.

199. Minutes of all meetings of the Patient Care Review Committee shall be recorded by the Chief Executive Officer (or delegate), or in his/her absence by some other person appointed to do so.

200. Minutes shall be submitted to the Medical Advisory Committee and also distributed to all those entitled to attend meetings of the Patient Care Review Committee prior to the next meeting.

201. No business shall be considered at a meeting of the Patient Care Review Committee until the minutes of the previous meeting have been confirmed or otherwise disposed of.

202. Minutes of a meeting shall be confirmed by resolution and signed by the chairperson at the next meetings and minutes so confirmed and signed shall be taken as evidence of the proceedings.

Statutory Immunity

203. Statutory immunity approval under the relevant State legislation for the Patient Care Review Committee may only be sought with the prior approval of the Chief Executive Officer.

204. No other committee or sub-committee of the Hospital shall seek any such statutory immunity or approval unless with the prior approval of the Chief Executive Officer.

K. GENERAL PROVISIONS

Conflict of Interest

205. A member of any Hospital committee or a person authorised to attend any committee meeting who has a direct or indirect pecuniary interest, a conflict or potential conflict of interest, or a direct or indirect material personal interest:

(a) in a matter that has been considered or is about to be considered at a meeting, shall not participate in the relevant discussion or resolution of any such interest or matter; or

(b) in a thing being done or about to be done by the Hospital, shall as soon as possible after the relevant facts have come to the person's knowledge, disclose the nature of the interest at the meeting.

206. A disclosure by a person at a meeting of the committee that the person:

(a) is a member, or is in the employment of the specified company or other body;

(b) is a partner, or is in the employment, of a specified person; or

(c) has some other specified interest relating to a specified company or other body or a specified person;

shall be deemed to be a sufficient disclosure of the nature of the interest in any matter or thing relating to that company or other body or to that person which may arise after the date of the disclosure.

207. The committee shall cause particulars of any disclosure to be recorded and declared by the member or authorised person in writing on a pecuniary interest/conflict of interest/material interest declaration form.

208. The chairperson of the committee shall advise the Chief Executive Officer of any disclosure made pursuant to this By-Law.

209. The Chief Executive Officer, after consultation with the chairperson of the committee, shall make a determination in relation to the disclosure of an interest pursuant to this By-Law. Such determination may, but is not limited to, include making a determination that the member or person will not participate in the meeting when the matter is being considered, or that the member or person will not be present while the matter is being considered at the meeting, or that the member or person may not hold the relevant office for a specified period of time.

210. A person who holds shares in a company or related company that operates the Hospital shall not be regarded as having a conflict of interest.

211. For the purposes of this By-Law, the fact that a member of the Medical Advisory Committee is a member of a particular discipline shall not be regarded as a direct or indirect pecuniary interest, a conflict or potential conflict of interest or a direct or indirect material personal interest, if that committee member participates in the appointment process of an Accredited Practitioner in the same discipline.

Confidentiality

212. Accredited Practitioners will manage all matters related to the confidentiality of information in compliance with the 'Australian Privacy Principles' established by the Privacy Act (Cth) and Healthe Care or the relevant Hospital policy.

213. Accredited Practitioners will comply with the various statutes governing the collection and handling of health information that regulate the Hospital.

214. Accredited Practitioners will also comply with common law duties of confidentiality.

215. Every Accredited Practitioner must keep confidential the following information:

(a) business information concerning Healthe Care or the Hospital;

(b) the particulars of these By-Laws;

(c) information concerning Healthe Care's insurance arrangements;

(d) information concerning any patient or staff of the Hospital; and

(e) information which comes to their knowledge concerning patients, clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluable of clinical services of the Hospital.

216. In addition to statutory or common law exceptions to confidentiality, the confidentiality requirements do not apply in the following circumstances:

(a) where disclosure is required to provide continuing clinical care to the patient;

(b) where disclosure is required by law;

(c) where disclosure is made to a regulatory or registration body in connection with the Accredited Practitioner, the Hospital or Healthe Care;

(d) where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or

(e) where disclosure is required in order to perform some requirement of these By-Laws.

217. The confidentiality requirements continue with full force and effect after the Accredited Practitioner ceases to be accredited to the Hospital.

218. Accredited Practitioners acknowledge that in order for Healthe Care and its Hospitals to function, effective communication is required, including between the executive members of Healthe Care, executive members of the Hospital, committees of the Hospital and staff. Accredited Practitioners acknowledge and consent to communication between these

persons and entities of information, including their own personal information that may otherwise be restricted by the Privacy Act. The acknowledgment and consent is given on the proviso that information will be dealt with in accordance with obligations pursuant to the Privacy Act and only for proper purposes and functions.

Forms and Paperwork

219. Each Chief Executive Officer may prescribe forms (written or electronic) and other administrative processes to be completed by Accredited Practitioners in the treatment of their patients.

Disputes

220. Any dispute or difference which may arise as to the meaning or interpretation or application of these By-Laws or as to the powers of any committee or the validity of proceedings of any meeting shall be determined by the Chief Executive Officer of Healthe Care. There is no appeal from a determination by the Chief Executive Officer of Healthe Care.