

FACILITY BY-LAWS

By-laws and Professional Guidelines for Medical Practitioners, Dentists and
Allied Health Professionals

2016

These By-laws are adapted from the following generic Facility By-laws:

The Private Hospitals Association of Queensland (PHAQ) has commissioned Minter Ellison Lawyers to prepare generic Facility By-laws for use in various hospitals and health care facilities. PHAQ has a licence to use the By-laws and is permitted to grant sub-licences of the By-laws.

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I. Preface

Mater Health Services North Queensland Limited operate two fully accredited private hospitals, one established by the Sisters of Mercy in 1945 and the second purchased in 2007. The Hospital's Philosophy, Mission and Values are based on those of the Sisters of Mercy.

The **Mater Hospital Pimlico** is an acute Medical / Surgical facility with a present bed capacity of 165. The specialty areas include Cardiac Surgery, Coronary Care Unit, Intensive Care Unit, Cardiac Catheter Laboratory, Endoscopy / Interventional Radiology, Orthopaedics / Neurosurgical, Respiratory Laboratory, Respiratory Medicine, Neurology, Endocrinology, Bariatric Surgery, Dental, Oral Maxillofacial, Sleep Disorders and Post Traumatic Stress Disorder Unit.

The **Mater Women's and Children's Hospital Hyde Park** was established in 1986 and is a Medical / Surgical facility with a present bed capacity of 58. Specialty areas include Obstetrics, General Surgery, Orthopaedics, Urology, Oncology, Urodynamics, Plastic & Cosmetic Surgery, Otorolaryngology, Ophthalmology, Vascular Surgery, and Paediatrics.

Whilst the majority of the patients attending the Hospitals come from Townsville and surrounding districts, services are also regularly accessed by people from as far west as Mt Isa and beyond, North to Cairns and its surrounds and South to Mackay. The Hospitals have also treated occasional patients from the Northern Territory, Papua New Guinea, Vietnam and the Pacific Islands.

The Organisation is dedicated to providing medical excellence and compassionate care, and as such facilitates several post-graduate tertiary education programmes (in conjunction with James Cook University) in areas such as Intensive Care, Cardiac Nursing, Midwifery and Peri-Operative Nursing, Under graduate Nursing, Medicine and Physiotherapy and Graduate Nurse Year. The Mater's customer-focused culture is reflected in its ongoing accreditation with the Australian Council on Healthcare Standards (ACHS) since the mid 1980s.

2. Philosophy, Mission and Values

Philosophy

Sisters of Mercy believe that:

- Each person is created in God's own image and intimately loved by God.
- God intervened in human history in the person of Jesus Christ offering loving mercy to all.
- Christ's own suffering and death has shown us that in some mysterious way human suffering and even death, can become the way to a "new life".
- Their gift as Sisters of Mercy is to know God's loving mercy in their own lives and to share it with others.

Mission

Mater Health Services North Queensland Limited operates Catholic facilities inspired by the vision of Catherine McAuley, Foundress of the Sisters of Mercy. Those who minister here strive to:

- Offer a healing ministry based on Gospel values
- Achieve excellence in the provision of high quality health care
- Make God's love and mercy a reality in their own lives and in the lives of all for whom they care.

Values

Mercy Spirituality

"Happy the merciful, they shall have mercy shown them" (Mt.5:7)

"Mercy – the principal path pointed out by Jesus Christ to those who are desirous of following Him" (Catherine McAuley)

Acknowledgement of God in the everyday, which calls us to:

- An understanding of Catherine McAuley and her vision
- The practice of hospitality in our daily life
- The provision of Catholic/Christian symbols throughout the hospital
- The celebration of various movement's of the hospital's life through uplifting liturgies
- A firm commitment to responsible stewardship of our Mercy heritage
- Collaboration with community groups and other health professionals in providing Gospel-based health services
- A short time of reflection/prayer within our busy, working week

Compassion

"Filled with compassion, Jesus reached out His hand and touched the man." (Mk. 1:41)

"If our hearts be not moved, then in vain can we hope to move the hearts of others" (Catherine McAuley)

A heart that looks for every opportunity to:

- Welcome
- Listen
- Empathize
- Forgive
- Affirm

Excellence in Care

"Just as you excel in everything, in faith, in speech, in knowledge, in complete earnestness, and in your love for us – see that you also excel in the grace of giving." (2 Cor. 8:7)

"Perfection does not consist in performing extraordinary action, but rather in performing extraordinarily well the ordinary actions of every day." (Catherine McAuley)

Our hospital prides itself in providing:

- A high quality care for all patients
- Opportunities for keeping abreast of developments in medical science
- Regular staff in-service

Respect

"Be ready to do good at every opportunity, to be courteous and always polite to all kinds of people." (Titus 3:2)

"Be ever ready to praise, to encourage, to stimulate – but slow to censure and still slow to condemn." (Catherine McAuley)

A gracious disposition which:

- Seeks to act courteously and to build right relationships
- Reverences all peoples' traditions and religious convictions
- Upholds the dignity and integrity of patients, visitors and staff
- Regards confidentiality as a sacred trust
- Endeavours to speak in an uplifting and encouraging manner

Justice

"This is what God asks of you: only this, to act justly, to love tenderly and to walk humbly with your God." (Micah 6:8)

"There are three things that the poor prize more highly than gold, though they cost the donor nothing. These are the kind work, the gentle compassionate look and the patient hearing of their sorrows." (Catherine McAuley)

A gospel imperative which urges us to:

- Share resources with those in need
- To act justly
- Offer assistance regarding conflict resolution
- Commit a certain percentage of financial profit to the support of appropriate causes

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

Part A – Definitions and introduction

3. Definitions and interpretation

3.1 Definitions

In these By-laws, unless indicated to the contrary or the context otherwise requires:

Accreditation means the process provided for in these By-laws by which a person is Accredited. The two conditions for Accreditation are an explicit definition of quality (ie standards) and an independent review process aimed at identifying the level of congruence between practices and quality standards.

Accreditation Category means as part of Accreditation, the appointment of an Accredited Practitioner to one of more of the following categories: Allied Health Professional, Career Medical Officer, Dental Assistant, Dental Specialist, Dentist, Employed Medical Officer, General Medical Practitioner, Medical Practitioner, Nurse Practitioner, Specialist Medical Practitioner, Surgical Assistant – Medical Practitioner, Surgical Assistant – Non Medical Practitioner, or University Student. The Board may from time to time approve other Accreditation Categories.

Accreditation Type means as part of Accreditation, the appointment of an Accredited Practitioner with one or more of the following: admitting privileges, allied health privileges, anaesthetic privileges, assist privileges, consulting privileges, contract of employment privileges, diagnostic privileges, procedural privileges, surgical assist privileges – medical practitioner, surgical assist privileges – registered nurse, and surgical privileges. The Board may from time to time approve other Accreditation Types.

Accredited means the status conferred on a Medical Practitioner, Dentist or Allied Health Professional permitting them to provide services within the Facility after having satisfied the Credentialing requirements provided in these By-laws.

Accredited Practitioner means a Medical Practitioner, Dentist, Allied Health Professional or other practitioner who has been Accredited to provide services within the Facility, and who may be an **Accredited Medical Practitioner**, **Accredited Dentist** or **Accredited Allied Health Professional**, with Accreditation to perform services at the Facility within the Accreditation Category, Accreditation Type and Scope of Practice notified in the appointment.

Adequate Professional Indemnity Insurance means 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 Facility, and is in an amount and on terms that the Facility considers in its absolute discretion to be sufficient. The insurance must be adequate for Scope of Practice and level of activity.

Allied Health Privileges means the entitlement to provide treatment and care to Patients as an Allied Health Professional within the areas approved by the Board in accordance with the provisions of these By-laws.

Allied Health Professional means a person registered under the applicable legislation to practise as an Allied Health Professional in the State in which the Facility is located, or other categories of appropriately qualified health professionals as approved by the Board.

Behavioural Sentinel Event means an episode of inappropriate or problematic behaviour which indicates concerns about an Accredited Practitioner's level of functioning and suggests potential for adversely affecting Patient safety or Facility outcomes.

Board means the Board of Directors of the Facility.

By-laws means these By-laws.

Chief Executive Officer (CEO) means the most senior executive in the Facility or any person acting, or delegated to act, in that position.

Clinical Practice means the professional activity undertaken by Accredited Practitioners for the purposes of investigating Patient symptoms and preventing and/or managing illness, together with associated professional activities related to clinical care.

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 interpersonal relationships, decision making and Performance necessary for the Scope of Practice for which the person has applied and has the demonstrated ability to provide health services at an expected level of safety and quality.

Credentials means, in respect of a person who applies for Accreditation, the qualifications, professional training, clinical experience and training and experience in leadership, research, education, communication and teamwork that contribute to the person's Competence, Performance and professional suitability to provide safe, high quality health care services. The applicant's history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal record are relevant to their Credentials.

Credentialing means, in respect of a person who applies for Accreditation, the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of the applicant for the purpose of forming a view about their Credentials, Competence, Performance and professional suitability to provide safe, competent, ethical and high quality health care services within the Facility.

Current Fitness is the current fitness required of an applicant for Accreditation to carry out the Scope of Practice sought or currently held. A person is not to be considered as having current fitness if that person suffers from any physical or mental impairment, disability, condition or disorder (including habitual drunkenness or addiction to deleterious drugs) which detrimentally affects or is likely to detrimentally affect the person's physical or mental capacity to safely practice medicine, dentistry or allied health (as the case may be).

Dentist means, for the purposes of these By-laws, a person registered under the applicable legislation to practise dentistry in the State in which the Facility is located.

Director of Medical Services means the person appointed to that position in the Facility or any person acting, or delegated to act, in that position.

Disruptive Behaviour means aberrant behaviour manifested through personal interaction with Medical Practitioners, hospital personnel, health care professionals, Patients, family members, or others, which interferes with Patient care or could reasonably be expected to interfere with the process of delivering quality care or which is inconsistent with the values of the Facility.

Emergency Accreditation means the process provided in these By-laws whereby a Medical Practitioner, Dentist or Allied Health Professional is Accredited for a specified short period on short notice in an emergency situation.

Executive Director of Nursing means the person appointed to that position in the Facility or any person acting, or delegated to act, in that position.

External Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) external to the Facility.

Facility means Mater Health Services North Queensland Ltd.

Interim Accreditation means the process provided in By-laws whereby a Medical Practitioner, Dentist or Allied Health Professional is Accredited for a temporary period pending formal approval process.

Internal Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) internal to the Facility.

Medical Advisory Committee means the medical advisory committee of the Facility.

Medical Practitioner means, for the purposes of these By-laws, a person registered under the applicable legislation to practise medicine in the State in which the Facility is located.

New Clinical Services means clinical services, treatment, procedures, techniques, technology, instruments or other interventions that are being introduced into the organisational setting of the Facility for the first time, or if currently used are planned to be used in a different way, and that depend for some or all of their provision on the professional input of Medical Practitioners.

Organisational Capability means the Facility'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 be determined by consideration of the availability, limitations and/or restrictions of the services, staffing, facilities, equipment, and support services required. In some jurisdictions the approved level of service capability may be specified on the Facility licence to operate. Organisational Capability may also be referred to as service capability.

Organisational Need means the extent to which the Facility is required or intends 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 consumer and community needs and aspirations.

Patient means a person admitted to, or treated as a patient at, the Facility.

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.

Re-accreditation means the process provided in these By-laws by which a person who already holds Accreditation may apply for and be considered for Accreditation following the probationary period or expiry of any subsequent term.

Scope of Practice means the extent of an individual Accredited Practitioner's permitted Clinical Practice within the Facility based on the individual's Credentials, Competence, Performance and professional suitability, and the Organisational Capability and Organisational Need of the organisation to support the Accredited Practitioner's scope of clinical practice. Scope of Practice may also be referred to as delineation of clinical privileges.

Specialist Medical 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 (Cth) and is registered under the applicable legislation to practise medicine in that speciality in the State in which the Facility is located.

Temporary Accreditation means the process provided in By-laws whereby a Medical Practitioner, Dentist or Allied Health Professional is Accredited for a limited period.

Threshold Credentials means the minimum credentials for each clinical service, procedure or other intervention which applicants for Credentialing, within the Scope of Practice sought, are required to meet before any application will be processed and approved. Threshold credentials are to be approved by the Board and may be incorporated into an Accreditation policy.

Visiting Allied Health Professional means an Allied Health Professional who is not an employee of the Facility, and who has been granted Allied Health Accreditation and Scope of Practice pursuant to these By-laws.

Visiting Dentist means a Dentist who is not an employee of the Facility, who has been granted Accreditation and Scope of Practice pursuant to these By-laws.

Visiting Medical Practitioner means a Medical Practitioner who is not an employee of the Facility, who has been granted Accreditation and Scope of Practice pursuant to these By-laws. Visiting Medical Practitioners include visiting Specialist Medical Practitioners.

3.2 Interpretation

Headings in these By-laws are for convenience only and are not to be used as an aid in interpretation.

In these By-laws, unless the context makes it clear the rule of interpretation is not intended to apply, words importing the masculine gender shall also include feminine gender, words importing the singular shall also include the plural, if a word is defined another part of speech has a corresponding meaning, if an example is given the example does not limit the scope, reference to legislation (including subordinate legislation or regulation) is to that legislation as amended, re-enacted or replaced, reference to a standard, policy or procedure is to that document as updated or replaced and reference to an organisation will include any renaming of that organisation or any entity taking on responsibilities of that organisation.

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

The Board may delegate certain matters of decision-making or management of a particular matter as set out in these By-laws to a nominated Board member, other than determination of an appeal.

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 Board. There is no appeal from such a determination by the Board.

3.3 Meetings

Where a reference is made to a meeting, the quorum requirements that will apply are those specified in the terms of reference of the relevant committee. If there are no terms of reference, where there is an odd number of members a quorum will be a majority of the members, or where there is an even number of members a quorum will be half of the number of the members plus one.

Committee resolutions and decisions, if not specified in the terms of reference, must be supported by a show of hands or ballot of committee members at the meeting.

Voting, if not specified elsewhere, shall be on a simple majority voting basis and only by those in attendance at the meeting (including attendance by electronic means). There shall be no proxy vote.

In the case of an equality of votes, the chairperson will have the casting vote.

A committee established pursuant to these By-laws may hold any meeting by electronic means or by telephonic communication whereby participants can be heard.

Resolutions may be adopted by means of a circular resolution.

Information provided to any committee or person shall be regarded as confidential and is not to be disclosed beyond the purpose for which the information was made available, subject to the exceptions set out in these By-laws.

Any member of a committee who has a conflict of interest or material personal interest in a matter to be decided or discussed shall inform the chairperson of the committee and subject to any agreed resolution on the matter shall take no part in any relevant discussion or resolution with respect to that particular matter. This will include a member the Medical Advisory Committee or Credentialing Committee whose application for Accreditation is being considered.

4. Introduction

4.1 Purpose of this document and understanding of By-laws

- (a) The By-laws provide direction to the CEO and Board of Directors in relation to exercise of certain aspects of their managerial and governance responsibility.
- (b) Patient care is provided by Accredited Practitioners who have been granted access to use the Facility in order to provide that care.
- (c) The By-laws define the relationship and obligations between the Facility and its Accredited Practitioners.
- (d) This document sets out certain terms and conditions upon which Medical Practitioners, Dentists and Allied Health Professionals may apply to be Accredited within the defined Scope of Practice granted, the basis upon which a successful applicant may admit Patients and/or care and treat Patients at the Facility, and the terms and conditions for continued Accreditation.
- (e) This document sets out the entirety of the processes and procedures available to Accredited Practitioners with respect to all matters relating to and impacting upon Accreditation.
- (f) Every applicant for Accreditation will be given a copy of this document and Annexures before or at the time of making an application. It is expected that the By-laws are read in their entirety by the applicant as part of the application process.
- (g) The Facility aims to maintain a high standard of Patient care and to continuously improve the safety and quality of its services. The By-laws implement measures aimed at maintenance and improvements in safety and quality.
- (h) Health care in Australia is subject to numerous legislation and standards. The By-laws assist in compliance with certain aspects of this regulation but are not a substitute for review of the relevant legislation and standards.

Part B – Terms and conditions of Accreditation

5. Compliance with By-laws

5.1 Compliance obligations

- (a) It is a requirement for continued Accreditation that Accredited Practitioners comply with the By-laws at all relevant times when admitting, caring for or treating Patients, or otherwise providing services at the Facility.
- (b) Any non-compliance with the By-laws may be grounds for suspension, termination, or imposition of conditions.
- (c) Unless specifically determined otherwise by the Board in writing for a specified Accredited Practitioner, the provisions of these By-laws in their entirety prevail to the extent of any inconsistency with any terms, express or implied, in a contract of employment or engagement that may be entered into. In the absence of a specific written determination by the Board, 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 or employment or engagement.

5.2 Compliance with policies and procedures

Accredited Practitioners must comply with all policies and procedures of the Facility.

5.3 Compliance with legislation

Accredited Practitioners must comply with all relevant legislation, including but not limited to legislation that relates to health, public health, drugs and poisons, aged care, privacy, coroners, criminal law, health practitioner registration, research, environmental protection, workplace health & safety, occupational health and safety, antidiscrimination, bullying, harassment, industrial relations, care of children, care of persons with a disability, substituted decision making and persons with impaired capacity, mental health, Medicare, health insurance, fair trading and trade practices, intellectual property, and other relevant legislation regulating the Accredited Practitioner, provision of health care or impacting upon the operation of the Facility.

In addition, Accredited Practitioners must ensure compliance with, or assist the Facility to comply with, any Commonwealth or State mandated service capability frameworks or minimum standards, and any legislation imposing obligations upon the Facility.

5.4 Insurance and registration

Accredited Practitioners must at all times maintain Adequate Professional Indemnity Insurance.

Accredited Practitioners must at all times maintain registration with their relevant health registration board (local and/or national) that regulates the provision of services in the State where the Facility is located.

Accredited Practitioners are required to provide evidence annually, or at other times upon request, of Adequate Professional Indemnity Insurance and registration with the relevant health professional registration board, and all other relevant licences or registration requirements for the Scope of Practice granted. If further information is requested in relation to insurance or registration, the Accredited Practitioner will assist to obtain that information, or provide permission for the Facility to obtain that information directly.

5.5 Standard of conduct and behaviour

- (a) The Facility expects a high standard of professional and personal conduct and behaviour from Accredited Practitioners, who must conduct themselves and behave at all times in accordance with:
 - (i) the Code of Ethics of the Australian Medical Association or any other relevant code of ethics;
 - (ii) the Codes of Practice and Conduct, as well as associated Guidelines and Policies, of any specialist college or professional body or regulatory body of which the Accredited Practitioner is a member or registered. This includes for Medical Practitioners the *Good Medical Practice: A Code of Conduct for Doctors in Australia* and *Sexual Boundaries: Guidelines for Doctors*;
 - (iii) The Philosophy, Mission & Values of Mater Health Services North Queensland Ltd;
 - (iv) the strategic direction of the Facility, and any directions given by the Board;
 - (v) the limits of their registration or any conditions placed upon Scope of Practice in accordance with these By-laws;
 - (vi) Mater Health Services North Queensland Ltd Code of Professional Conduct;

- (vii) The Code of Ethical Standards for Catholic Health and Aged Care Services in Australia or its replacement;
- (viii) all reasonable requests made with regard to personal conduct in the Facility.
- (b) Accredited Practitioners must continuously demonstrate Competence and Current Fitness, must not engage in Disruptive Behaviour or any form of violence, aggression, threats, intimidation, bullying or harassment (including physical, verbal or online), must understand and comply with the codes, policies and procedures of the Facility in relation to these matters, and observe all reasonable requests with respect to conduct and behaviour.
- (c) Upon request by the CEO and/or Director of Medical Services, the Accredited Practitioner is required to meet with the CEO and/or Director of Medical Services and any other person that the CEO and/or Director of Medical Services may ask to attend the meeting, to discuss matters in a) or b) above, or any other matter arising out of these By-laws.

5.6 Notifications

Accredited Practitioners must immediately advise the CEO, and follow up with written confirmation within 2 days, should:

- (a) an investigation or complaint be commenced in relation to the Accredited Practitioner, or about his/her Patient (irrespective of whether this relates to a Patient of the Facility), by the Accredited Practitioner's registration board, disciplinary body, Coroner, a health complaints body including the Office of Health Ombudsman, or another statutory authority, State or Government agency;
- (b) an adverse finding (including but not limited to criticism or adverse comment about the care or services provided by the Accredited Practitioner) be made against the Accredited Practitioner by a civil court, the practitioner's registration board, disciplinary body, Coroner, a health complaints body including the Office of Health Ombudsman, or another statutory authority, State or Government agency, irrespective of whether this relates to a Patient of the Facility;
- (c) the Accredited Practitioner's professional registration be revoked or amended or limited, or should conditions be imposed, or should undertakings be agreed, irrespective of whether this relates to a Patient of the Facility and irrespective of whether this is noted on the public register or is privately agreed with a registration board;
- (d) professional indemnity membership or insurance be made conditional, reduced or not renewed, or should limitations be placed on insurance or professional indemnity coverage;
- (e) the Accredited Practitioner's appointment, clinical privileges or Scope of Practice at any other facility, hospital or day procedure centre alter in any way, including if it is resigned, withdrawn, suspended, restricted, or made conditional, and irrespective of whether this was done by way of agreement;
- (f) 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 to enable him or her to practise safely and competently;
- (g) the Accredited Practitioner be charged with having committed or is convicted of a any criminal offence. The Accredited Practitioner must provide the Facility with an authority to conduct at any time a criminal history check with the appropriate authorities;
- (h) the Accredited Practitioner believe that Patient care or safety is being compromised or at risk, or may potentially be compromised or at risk, by another Accredited Practitioner of the Facility; or

- (i) the Accredited Practitioner make a mandatory notification to a health practitioner registration board in relation to another Accredited Practitioner of the Facility.

In addition, Accredited Practitioners should inform themselves of their personal obligations in relation to external notifications (including mandatory notifications) and ensure compliance with these obligations.

5.7 Continuous disclosure

- (a) The Accredited Practitioner must keep the CEO continuously informed of every fact and circumstances which has, or will likely have, a material bearing upon:
 - (i) the Accreditation of the Accredited Practitioner;
 - (ii) the Scope of Practice of the Accredited Practitioner;
 - (iii) the ability of the Accredited Practitioner to safely deliver health services to his/her Patients within the Scope of Practice;
 - (iv) the Accredited Practitioner's registration or professional indemnity insurance arrangements;
 - (v) the ability of the Accredited Practitioner to satisfy a medical malpractice claim by a Patient;
 - (vi) adverse outcomes, complications or complaints in relation to the Accredited Practitioner's Patients (current or former) of the Facility;
 - (vii) the reputation of the Accredited Practitioner as it relates to the provision of Clinical Practice; and
 - (viii) the reputation of the Facility.
- (b) Subject to restrictions directly relating to or impacting upon legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the CEO informed and updated about the commencement, progress and outcome of compensation claims, coronial investigations or inquests, police investigations, Patient complaints, health complaints body complaints or investigations including by the Office of Health Ombudsman, or other inquiries involving Patients of the Accredited Practitioner that were treated at the Facility.

5.8 Representations and media

Unless an Accredited Practitioner has the prior written consent of the CEO, an Accredited Practitioner may not use the Facility's (which for the purposes of this provision includes a corporate or business name of the Facility, its parent companies or subsidiary companies) name, letterhead, or in any way suggest that the Accredited Practitioner represents these entities.

The Accredited Practitioner must obtain the CEO's prior approval before interaction with the media regarding any matter involving the Facility.

5.9 Committees

- (a) The Facility requires Accredited Practitioners, as reasonably requested by the CEO/Board, to assist it in achieving its goals and strategic direction, and provision of high level care and services, through membership of committees of the Facility. This includes committees responsible for developing, implementing and reviewing policies in all clinical areas; participating in medical, nursing and other education programs; and attending meetings of Medical Practitioners, Dentists and/or Allied Health Professionals.

5.10 Confidentiality

- (a) Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with the Facility's policy, the 'Australian Privacy Principles' established by the *Privacy Act (Cth)*, and other legislation and regulations relating to privacy and confidentiality, and will not do anything to bring the Facility in breach of these obligations.
- (b) Accredited Practitioners will comply with the various legislation governing the collection, handling, storage and disclosure of health information.
- (c) Accredited Practitioners will comply with common law duties of confidentiality.
- (d) The following will also be kept confidential by Accredited Practitioners:
 - (i) Commercial in confidence business information concerning the Facility;
 - (ii) The particulars of these By-laws;
 - (iii) Information concerning the Facility's insurance arrangements;
 - (iv) information concerning any Patient or staff of the Facility;
 - (v) information which comes to their knowledge concerning Patients, Clinical Practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services.
- (e) In addition to statutory or common law exceptions to confidentiality, the confidentiality requirements do not apply in the following circumstances:
 - (i) where disclosure is required to provide continuing care to the Patient;
 - (ii) where disclosure is required by law;
 - (iii) where disclosure is made to a regulatory or registration body in connection with the Accredited Practitioner, another Accredited Practitioner, or the Facility;
 - (iv) where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or
 - (v) where disclosure is required in order to perform some requirement of these By-laws.
- (f) The confidentiality requirements continue with full force and effect after the Accredited Practitioner ceases to be Accredited.

5.11 Communication

Accredited Practitioners are required to familiarise themselves with the organisational structure of the Facility.

Accredited Practitioners acknowledge that in order for the organisation to function, effective communication is required, including between the Board, CEO, Director of Medical Services, Executive Director of Nursing, Executive Members and Committees of the Facility, staff of the Facility and other Accredited Practitioners.

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 the information will be dealt with in accordance with obligations pursuant to the *Privacy Act* and only for proper purposes and functions.

6. Safety and quality

6.1 Admission, availability, resources, communication, & discharge

- (a) All Accredited Practitioners shall admit or treat Patients at the Facility on a regular basis and be an active provider of services at the Facility.
- (b) Accredited Practitioners will admit and treat Patients only within the Accreditation Category, Accreditation Type and Scope of Practice granted, including any terms or conditions attached to the approval of Accreditation.
- (c) Accredited Practitioners will not provide services or practice outside of the defined service capability of the Facility.
- (d) Accredited Practitioners will, subject to clinical considerations, comply with all reasonable requests with regard to the use of medical supplies, prostheses and equipment and the provision of services at the Facility.
- (e) Accredited Practitioners who admit Patients to the Facility for treatment and care accept that they are at all times responsible for the care of their Patient and must ensure that they are available to treat and care for those Patients at all times, or failing that, that other arrangements as permitted by the By-laws are put in place to ensure the continuity of treatment and care for those Patients.
- (f) A Visiting Medical Practitioner who is unable, for whatever reason, to provide continuity of care for a patient must notify the Hospital administration of the name of the Visiting Medical Practitioner to whom the care of the patient has been delegated and for what period of time. A Practitioner who leaves the City of Townsville whilst having a patient admitted to the Hospital is deemed to be unable to provide continuity of care. Such delegation should be noted in the patient record by the responsible practitioner.
- (g) Accredited Practitioners must visit all Patients admitted or required to be treated by them as frequently as is required by the clinical circumstances of those Patients and as would be judged appropriate by professional peers. An Accredited Practitioner will be contactable to review the Patient in person or their on-call or locum cover is available as requested by nursing staff to review the Patient in the Facility. Accredited Practitioners must ensure that all reasonable requests by Facility staff are responded to in a timely manner and in particular Patients are promptly attended to when reasonably requested by Facility staff for clinical reasons. If Accredited Practitioners are unable to provide this level of care personally, he/she shall secure the agreement of another Accredited Practitioner to provide the care and treatment, and shall advise the staff of the Facility of this arrangement.
- (h) Accredited Practitioners must be available and attend upon Patients of the Accredited Practitioner in a timely manner when requested by Facility staff or be available by telephone in a timely manner to assist Facility 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, and shall advise the staff of the Facility of this arrangement.
- (i) It is the responsibility of the Accredited Practitioner to ensure any changes to contact details are notified promptly to the CEO. 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.
- (j) A locum must be approved in accordance with these By-laws and the Accredited Practitioner must ensure that the locum's contact details are made available to the Facility and all relevant persons are aware of the locum cover and the dates of locum cover.

- (k) Accredited Practitioners 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 Facility 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.
- (l) The Accredited Practitioner must appropriately supervise the care that is provided by the Facility staff and other practitioners. This includes providing adequate instructions to, and supervision of, Facility staff to enable staff to understand what care the Accredited Practitioner requires to be delivered.
- (m) Adequate instructions and clinical handover, including verbal and written, is required to be given to the Facility staff and other practitioners (including their on-call and locum cover) to enable them to understand what care the Accredited Practitioner requires to be delivered.
- (n) If care is transferred to another Accredited Practitioner, this must be noted on the Patient medical record and communicated to the Executive Director of Nursing or other responsible nursing staff member.
- (o) Accredited Practitioners must participate in formal on call arrangements as reasonably required by the Facility. Persons providing on-call or cover services must be Accredited at the Facility.
- (p) The Accredited Practitioner must ensure that their Patients are not discharged without the approval of the Accredited Practitioner, complying with the discharge policy of the Facility and completing all Patient discharge documents required by the Facility. It is the responsibility of the Accredited Practitioner to ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the referring practitioner, general practitioner and/or other treating practitioner.

6.2 Surgery

Accredited Practitioners must effectively utilise allocated theatre sessions that have been requested by the Accredited Practitioner.

Accredited Practitioners may only utilise as surgical assistants practitioners Accredited in accordance with these By-laws.

Accredited Practitioners acknowledge the importance of, and will participate in, various measures aimed at ensuring safety and quality during surgery, which includes but is not limited to participating in or allowing to occur procedures relating to correct site surgery, team time out, infection control and surgical item counts.

6.3 Facility, State Based and National Safety Programs, Initiatives and Standards

Accredited Practitioners acknowledge the importance of ongoing safety and quality initiatives that may be instituted by the Facility based upon its own safety and quality program, or safety and quality initiatives, programs, requirements or standards of State or Commonwealth health departments, private health insurers, statutory bodies or safety and quality organisations (including for example the national Australian Commission on Safety and Quality in Health Care).

Accredited Practitioners will participate in and ensure compliance with these initiatives and programs (including if they are voluntary initiatives that the Facility elects to participate in or undertake), whether these apply directly to the Accredited Practitioner or are undertaken by the Facility and require assistance from the Accredited Practitioner to ensure compliance.

Accredited Practitioners shall comply with, and take all reasonable actions to assist the Facility to comply with, each of the National Safety and Quality Health Service Standards issued by the Australian Commission on Safety and Quality in Health Care and any associated clinical guidelines, as well as contractual requirements relating to safety, quality and adverse/preventable events contractually agreed with private health insurers.

6.4 Treatment and financial consent

Accredited Practitioners must obtain fully informed consent for treatment (except where it is not practical in cases of emergency) from the Patient or their legal guardian or substituted decision maker in accordance with accepted medical and legal standards (including applicable legislation) and in accordance with the policy and procedures of the Facility.

For the purposes of this provision, 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.

The consent will be evidenced in writing and signed by the Accredited Practitioner and Patient or their legal guardian or substituted decision maker.

It is expected that fully informed consent will be obtained by the Accredited Practitioner under whom the Patient is admitted or treated, with this the sole legal responsibility of the Accredited Practitioner. The consent process will ordinarily include an explanation of the Patient's condition and prognosis, treatment and alternatives, inform the Patient of material risks associated with treatment and alternatives, following which consent to the treatment will be obtained.

The consent process must also satisfy the Facility's requirements from time to time as set out in its policy and procedures, including in relation to the documentation to be provided to the Facility.

Accredited Practitioners must provide full financial disclosure and obtain fully informed financial consent from their Patients in accordance with the relevant legislation, health fund agreements, policy and procedures of the Facility.

6.5 Patient Records

Accredited Practitioners must ensure that:

- (a) Patient records held by the Facility are adequately maintained for Patients treated by the Accredited Practitioner, with ownership and copyright of entries contained in the Facility records vesting in the Facility;
- (b) Patient records satisfy the Facility policy requirements, legislative requirements, State based standards, the content and standard required by the Australian Council on Healthcare Standards, accreditation requirements, and health fund obligations;
- (c) they maintain full, accurate, legible and contemporaneous medical records, including in relation to each attendance upon the Patient, with the entries dated, time and signed and contained in the Facility medical records;
- (d) if introduced within the Facility or a part of the Facility, they participate in electronic medical record and ehealth initiatives;
- (e) they comply with all legal requirements and standards in relation to the prescription and administration of medication, and properly document all drugs orders clearly and legibly in the medication chart maintained by the Facility;
- (f) Patient records maintained by the Facility include all relevant information and documents reasonably necessary to allow Facility staff and other Accredited Practitioners to care for

Patients, including provision of pathology, radiology and other investigative reports in a timely manner;

- (g) A procedure report is completed including a detailed account of the findings, technique undertaken, complications and post procedure orders;
- (h) An anaesthetic report is completed, as well as documentation of the pre-anaesthetic evaluation, fully informed anaesthetic consent and post-anaesthetic evaluation;
- (i) A discharge summary is completed that includes all relevant information reasonably required by the referring practitioner, general practitioner or other treating practitioner for ongoing care of the Patient.

6.6 Financial information and statistics

- (a) Accredited Practitioners must record all data required by the Facility to meet health fund obligations, collect revenue and allow compilation of health care statistics.
- (b) Accredited Practitioners must ensure that all Pharmaceutical Benefits Scheme prescription requirements and financial certificates are completed in accordance with Facility policy and regulatory requirements.

6.7 Quality improvement, risk management and regulatory agencies

- (a) Accredited Practitioners are required to attend and participate in the Facility's safety, quality, risk management, education and training activities, including clinical practice review and peer review activities, and as required by relevant legislation, standards and guidelines (including those standards and guidelines set by relevant Commonwealth or State governments, health departments or statutory health organisations charged with monitoring and investigating safety and quality of health care).
- (b) Accredited Practitioners will report to the Facility incidents, complications, adverse events, preventable events as set out in lists prepared by private health insurers/health funds, and complaints (including in relation to the Accredited Practitioner's Patients) in accordance with the Facility policy and procedures and where required by the CEO will assist with incident management, investigation and reviews (including root cause analysis and other systems reviews), complaints management, and open disclosure processes.
- (c) Accredited Practitioners will participate in risk management activities and programs, including the implementation by the Facility of risk management strategies and recommendations from system reviews.
- (d) Accredited Practitioners must provide all reasonable and necessary assistance in circumstances where the Facility requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction or contractual obligation, including for example where that direction is pursuant to a court order, or from a health complaints body (including the Office of Health Ombudsman), Coroner, Police, State Health Department and its agencies or departments, State Private Health Regulatory/Licensing Units, Commonwealth Government and its agencies or departments, or private health insurers/health funds.

6.8 Clinical speciality committees

The CEO may establish clinical speciality committees for the purpose of reviewing and advising the CEO on performance of the clinical speciality by reference to the Facility's clinical services, Organisational Capability and Organisational Need. These committees may include but are not limited to peer review and quality activities.

Each clinical speciality committee, in consultation with the CEO, will establish terms of reference for the committee and will report annually, or as required by the CEO, on its activities to the Medical

Advisory Committee, and make recommendations to the Medical Advisory Committee on issues relevant to the clinical speciality.

6.9 Participation in clinical teaching activities

Accredited Practitioners, if requested, are required to reasonably participate in the Facility's clinical teaching program.

6.10 Research

- (a) The Facility approves, in principle, the conduct of research (including a clinical trial) in the Facility. However, no research will be undertaken without the prior approval of the CEO and a Human Research Ethics Committee, following written application by the Accredited Practitioner.
- (b) The activities to be undertaken in the research must fall within the Scope of Practice of the Accredited Practitioner.
- (c) For aspects of the research falling outside a indemnity from a third party (including the exceptions listed in the indemnity), the Accredited Practitioner must have in place adequate insurance with a reputable insurer to cover the medical research.
- (d) Research will be conducted in accordance with National Health and Medical Research Council requirements, National Statement on Ethical Conduct in Human Research 2007 (as amended and updated from time to time), and other applicable legislation.
- (e) An Accredited Practitioner has no power to bind the Facility to a research project (including a clinical trial) by executing a research agreement.
- (f) There is no right of appeal from a decision to reject an application for research.

6.11 Obtain written approval for New Clinical Services

- (a) Before treating patients with New Clinical Services, an Accredited Practitioner is required to obtain the prior written approval of the CEO and what is proposed must fall within the Accredited Practitioner's Scope of Practice or an amendment to the Scope of Practice has been obtained and must fall within the licensed service capability of the facility.
- (b) The Accredited Practitioner must provide evidence of Adequate Professional Indemnity Insurance to cover the New Clinical Service, and if requested, evidence that private health funds will adequately fund the New Clinical Services.
- (c) If research is involved, then the By-law dealing with research must be complied with.
- (d) The CEO's decision is final and there shall be no right of appeal from denial of requests for New Clinical Services.

6.12 Utilisation

Accredited Practitioners will be advised upon Accreditation or Re-Accreditation, or at other times as determined by the CEO, of the expectations in relation to exercising Accreditation and utilisation of the facility. Absent special circumstances, the Accredited Practitioner must exercise Accreditation or utilise the Facility in accordance with the specified expectations.

Part C – Accreditation of Medical Practitioners

7. Credentialing and Scope of Practice

7.1 Eligibility for Accreditation as a Medical Practitioner

Accreditation as a Medical Practitioner will only be granted if the Medical Practitioner demonstrates adequate Credentials, is professionally Competent, satisfies the requirements of the By-laws, and is prepared to comply with the By-laws and the Facility policies and procedures.

By the granting of Accreditation, the Medical Practitioner accepts compliance with and agrees to abide by the By-laws and the Facility policies and procedures.

Any Medical Practitioner who falls outside of Accreditation requirements and therefore is not subject to a Credentialing process, before being permitted to attend the Facility and be involved in clinical care of Patients, will be provided with and agree to 'terms of attendance' (however phrased) that will govern attendance at the Facility, including appropriate supervision.

7.2 Entitlement to treat Patients at the Facility

- (a) Medical Practitioners who have received Accreditation pursuant to the By-laws are entitled to make a request for access to facilities for the treatment and care of their Patients within the limits of the Accreditation Category, Accreditation Type and Scope of Practice attached to such Accreditation at the Facility and to utilise services and equipment provided by the Facility for that purpose, subject to the provisions of the By-laws, Facility policies, resource limitations, and in accordance with Organisational Need and Organisational Capability.
- (b) The decision to grant access to facilities for the treatment and care of a Medical Practitioner's Patients is on each occasion within the sole discretion of the Board and the grant of Accreditation contains no conferral of, or a general expectation of, or a 'right of access'.
- (c) A Medical Practitioner's use of the facilities for the treatment and care of Patients is limited to the Scope of Practice granted by the Board and subject to the conditions upon which the Scope of Practice is granted, resource limitations, and Organisational Need and Organisational Capability. Accredited Practitioners acknowledge that admission or treatment of a particular Patient is subject always to bed availability, the availability or adequacy of nursing or allied health staff or facilities given the treatment or clinical care proposed.

7.3 Responsibility and basis for Accreditation and granting of Scope of Practice

The Board will determine the outcome of applications for Accreditation as Medical Practitioners and defined Scope of Practice for each applicant. In making any determination, the Board will make independent and informed decisions and in so doing will have regard to the matters set out in these By-laws, the recommendations of the Medical Advisory Committee and any feedback from the CEO and Director of Medical Services. The Board may, at their discretion, consider other matters as relevant to the application when making their determination.

7.4 Principles of Credentialing and Accreditation

The following principles should be considered and guide those persons involved in making 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 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 and transparent, although recognising the ultimate ability of the Board and CEO to make decisions that they consider to be in the best interests of the organisation, its current and future patients.

7.5 Medical Advisory Committee

The CEO shall convene a Medical Advisory Committee and it will function in accordance with the terms of reference established for the Medical Advisory Committee and pursuant to any requirements set out in these By-laws.

The Medical Advisory Committee members, including the chairperson, will be Accredited Practitioners (or at least a majority of Accredited Practitioners) and will be appointed by the Board for such period as determined by the Board and may be removed from membership of the committee by the Board.

The Board may establish a Credentialing Committee, which will be a sub-committee of the Medical Advisory Committee. The Credentialing Committee will function in accordance with the terms of reference established for that committee. The primary role of a Credentialing Committee will be to conduct some aspects of the Credentialing requirements set out in these By-laws and make recommendations to the Medical Advisory Committee. In the event a Credentialing Committee is established, the responsibilities set out in these By-laws in relation to Credentialing will still ultimately remain with the Medical Advisory Committee and Board.

The terms of reference for the Credentialing Committee will include a process that provides for closing the Medical Advisory Committee meeting and reconvening it as a Credentialing Committee meeting, including recording of separate minutes.

In addition to the terms of reference established for the Medical Advisory Committee or Credentialing Committee, the Committees must be constituted according to and the members of the Committees must conduct themselves in accordance with any legislative obligations, including standards that have mandatory application to the Facility and Committee members.

The CEO, Director of Medical Services and Executive Director of Nursing will be entitled to attend meetings of the Medical Advisory Committee as ex-officio members, such that they will not have an entitlement to vote in relation to decisions or recommendations of the Medical Advisory Committee and Credentialing Committee.

In making determinations about applications for Accreditation there will ordinarily be at least one member of the same speciality as the applicant on the Medical Advisory Committee, which may mean co-opting a committee member in order to assist with the determination. It is, however, recognised that this may not always be possible or practicable in the circumstances, and a failure to do so will not invalidate the recommendation of the Medical Advisory Committee.

8. The process for appointment and re-appointment

8.1 Applications for Initial Accreditation and Re-Accreditation as Medical Practitioners

- (a) Applications for Initial Accreditation (where the applicant does not currently hold Accreditation at the Facility) and Re-Accreditation (where the applicant currently holds Accreditation at the Facility) as Medical Practitioners must be made in writing on the prescribed form. All questions on the prescribed form must be fully completed and all required information and documents supplied before an application will be considered. Applications should be forwarded to the CEO at least six weeks prior to the Medical Practitioner seeking to commence at the Facility or at least two months prior to expiration of the current Accreditation. Where this timeframe is unable to be achieved due to Organisational Need or patient needs, Temporary Accreditation or Emergency Accreditation will be considered at the discretion of the CEO. The prescribed form shall be approved by the Medical Advisory Committee and the Board.
- (b) Applications will include a declaration signed by the Medical Practitioner to the effect that the information provided by the Medical Practitioner is true and correct, and that the Medical Practitioner will comply in every respect with the By-laws in the event that the Medical Practitioner's application for Accreditation is approved.
- (c) The CEO and/or Director of Medical Services may interview Medical Practitioners and/or request further information from applicants that the CEO and/or Director of Medical Services considers appropriate.
- (d) The CEO will ensure that applications are complete and requests for further information complied with, and upon being satisfied will refer applications, together with notes from any interview conducted and feedback, to the Medical Advisory Committee for consideration.

8.2 Consideration by the Medical Advisory Committee

- (a) The Medical Advisory Committee will consider all applications for Accreditation and Re-Accreditation referred to it by the CEO.
- (b) Consideration by the Medical Advisory Committee will include but not be limited to information relevant to Credentials, Competence, Current Fitness, Organisational Capability and Organisational Need.
- (c) The Medical Advisory Committee will make recommendations to the Board as to whether the application should be approved and if so, on what terms, including the Accreditation Category, Accreditation Type and Scope of Practice to be granted.
- (d) The Medical Advisory Committee will act and make recommendations in accordance with its terms of reference and any relevant policy, as amended from time to time, including in relation to the consideration of applications for Accreditation and Re-Accreditation.
- (e) In instances where the Medical Advisory Committee has doubts about a Medical Practitioner's ability to perform the services, procedures or other interventions which may have been requested for inclusion in the Scope of Practice, they may recommend to the Board to:
 - (i) initiate an Internal Review;
 - (ii) initiate an External Review;
 - (iii) grant Scope of Practice for a limited period of time followed by review;
 - (iv) apply conditions or limitations to Scope of Practice requested; and/or
 - (v) apply requirements for relevant clinical services, procedures or other interventions to be performed under supervision or monitoring.

- (f) If the Medical Practitioner's Credentials and assessed Competence and performance do not meet the Threshold Credentials (if any) established for the requested Scope of Practice, the Medical Advisory Committee may recommend refusal of the application.

8.3 Consideration of applications for Initial Accreditation by the Board

- (a) The Board will consider applications for initial Accreditation as Medical Practitioners referred to the Board by the Medical Advisory Committee and will decide whether the applications should be rejected or approved and, if approved, whether any conditions should apply.
- (b) In considering applications, the Board will give due consideration to the recommendations of the Medical Advisory Committee as well as any feedback of the CEO or Director of Medical Services, but the final decision is that of the Board and the Board is not bound by the recommendation of the Medical Advisory Committee. In addition to considering the recommendations of the Medical Advisory Committee, including Organisational Capability and Organisational Need, the Board may consider any matter assessed as relevant to making the determination in the circumstances of a particular case.
- (c) The Board may defer consideration of an application in order to obtain further information from the CEO and Medical Advisory Committee, the Medical Practitioner or any other person or organisation.
- (d) If the Board requires further information from the Medical Practitioner before making a determination, they will forward a letter to the Medical Practitioner:
 - (i) informing the Medical Practitioner that the Board requires further information from the Medical Practitioner before deciding the application;
 - (ii) identifying the information required. This may include, but is not limited to, information from third parties such as other hospitals relating to current or past Accreditation, Scope of Practice and other issues relating to or impacting upon the Accreditation with that other hospital; and
 - (iii) requesting that the Medical Practitioner provide the information in writing or consent to contacting a third party for information or documents, together with any further information the Medical Practitioner considers relevant within fourteen (14) days from the date of receipt of the letter.
- (e) In the event that the information or documents requested by the Board is not supplied in the time set out in the letter, the Board may, at their discretion, reject the application or proceed to consider the application without such additional information.
- (f) The CEO will forward a letter to the Medical Practitioner advising the Medical Practitioner whether the application has been approved or rejected. If the application has been approved, the letter will also contain details of the Accreditation Category, Accreditation Type and Scope of Practice granted.
- (g) The CEO will ensure that information relating to Accreditation Category, Accreditation Type and Scope of Practice is accessible to those providing clinical services within the Facility.
- (h) There is no right of appeal from a decision to reject an application for initial Accreditation, or any terms or conditions that may be attached to approval of an application for initial Accreditation.

8.4 Initial Accreditation tenure

- (a) Initial Accreditation as a Medical Practitioner at the Facility will be for a probationary period of one year.

- (b) Prior to the end of the probationary period, a review of the Medical Practitioner's level of Competence, Current Fitness, Performance, compatibility with Organisational Capability and Organisational Need, and confidence in the Medical Practitioner will be undertaken by the CEO. The CEO will seek assistance with the review from the relevant Medical Advisory Committee or Speciality Committee where established, and may seek input from the Director of Medical Services. The CEO may also initiate the review at any time during the probationary period where concerns arise about Performance, Competence, Current Fitness of, or confidence in the Medical Practitioner, or there is evidence of Behavioural Sentinel Events exhibited by the Medical Practitioner.
- (c) In circumstances where, in respect of a Medical Practitioner:
 - (i) a review conducted by the CEO at the end of the probationary period, or
 - (ii) a review conducted by the CEO at any time during the probationary period, causes the CEO to consider:
 - (iii) the Medical Practitioner's Scope of Practice should be amended for any subsequent Accreditation granted, or
 - (iv) the probationary period should be terminated, or
 - (v) the probationary period should be extended, or
 - (vi) the Medical Practitioner should not be offered further Accreditation,
 the Medical Practitioner will be:
 - (vii) notified of the circumstances which have given rise to the relevant concerns, and
 - (viii) be given an opportunity to be heard and present his/her case.
- (d) Should the probationary review outcome, including information obtained in paragraph (c) above, be considered by the CEO to be unacceptable or insufficient, the CEO may recommend to the Board to:
 - (i) amend the Scope of Practice that will granted for any subsequent Accreditation; or
 - (ii) reject the continuation of Accreditation.
- (e) Should the Medical Practitioner have an acceptable probationary review outcome, the CEO may recommend to the Board that it grant an additional Accreditation period of up to five years, on receipt of a signed declaration from the Medical Practitioner describing any specific changes, if any, to the initial information provided and ongoing compliance with all requirements as per the By-laws.
- (f) The Board on recommendation from the CEO will make the final determination on Accreditation for all Medical Practitioners at the end of the probationary period. There will be no right of appeal at the end of the probationary period for a determination that Accreditation will not be granted following conclusion of the probationary period, or to any terms or conditions that may be attached to the grant of any Accreditation following the probationary period. All Medical Practitioners shall agree with this as a condition of initial Accreditation.

8.5 Re-Accreditation

- (a) The CEO will, at least two months prior to the expiration of any term of Accreditation of each Medical Practitioner (other than a probationary period), provide to that Medical Practitioner an application form to be used in applying for Re-Accreditation.

- (b) Any Medical Practitioner wishing to be Re-Accredited must send the completed application form to the CEO at least one month prior to the expiration date of the Medical Practitioner's current term of Accreditation.
- (c) If an Accredited Practitioner in the preceding 12 months prior to receipt of the application has not admitted or treated a Patient at the Facility, the CEO in consultation with the Board may elect to notify the Accredited Practitioner that the application for Re-Accreditation has not been accepted due to the failure to exercise Accreditation sufficiently and any future application will need to be in accordance with the process for an Initial Accreditation.
- (d) The CEO, Medical Advisory Committee and Board will deal with applications for Re-Accreditation in the same manner in which they are required to deal with applications for initial Accreditation as Medical Practitioners.
- (e) The rights of appeal conferred upon Medical Practitioners who apply for Re-Accreditation as Medical Practitioners (excepting applications for Accreditation after the probationary period) are set out in these By-laws.
- (f) If, upon receiving an application for Re-accreditation, the Credentialing Committee considers that it has material before it which may lead to a recommendation not to grant Re-accreditation of the applicant, the Credentialing Committee shall:
 - I. Provide the applicant with a copy of that material;
 - II. Seek a written submission from the applicant in relation to the material; and
 - III. Provide the applicant with an opportunity to address the Credentialing Committee prior to the Credentialing Committee forwarding its recommendation under clause 8.5(d).

8.6 Re-Accreditation tenure

Granting of Accreditation and Scope of Practice subsequent to the probationary period will be for a term of up to five years, as determined by the Board.

8.7 Nature of appointment

- (a) Accreditation does not of itself constitute an employment contract nor does it establish of itself a contractual relationship between the Medical Practitioner and the Facility.
- (b) The granting of Accreditation establishes only that the Accredited Practitioner is a person able to provide services at the Facility, as well as the obligations and expectations with respect to the Accredited Practitioner while providing services at the Facility for the period of Accreditation.
- (c) The granting of Accreditation creates no rights or legitimate expectation with respect to access to the Facility or its resources.
- (d) Accreditation is personal and cannot be transferred to, or exercised by, any other person.

9. Extraordinary Accreditation

9.1 Temporary Accreditation

- (a) The CEO may grant Medical Practitioners Temporary Accreditation and Scope of Practice on terms and conditions considered appropriate by the CEO. Temporary Accreditation will only be granted on the basis of Patient need, Organisational Capability and Organisational Need. The CEO may consider Emergency Accreditation for short notice requests.
- (b) Applications for Temporary Accreditation as Medical Practitioners must be made in writing on the prescribed form as for initial applications for Accreditation. All questions on the prescribed

form must be fully completed and required information and documents submitted before an application will be considered.

- (c) Temporary Accreditation may be terminated by the CEO for failure by the Medical Practitioner to comply with the requirements of the By-laws or failure to comply with Temporary Accreditation requirements.
- (d) Temporary Accreditation will automatically cease upon a determination by the CEO of the Medical Practitioner's application for Accreditation or at such other time as the CEO decides.
- (e) The period of Temporary Accreditation shall be determined by the CEO, which will be for a period of no longer than three (3) months.
- (f) There can be no expectation that a grant of Temporary Accreditation will mean that there is be a subsequent granting of Accreditation.
- (g) The Medical Advisory Committee and the Board will be informed of all Temporary Accreditation granted.
- (h) There will be no right of appeal from decisions relating to the granting of Temporary Accreditation or termination of Temporary Accreditation.

9.2 Emergency Accreditation

- (a) In the case of an emergency, any Medical Practitioner, to the extent permitted by the terms of the Medical Practitioner's registration, may request Emergency Accreditation and granting of Scope of Practice in order to continue the provision of treatment and care to Patients. Emergency Accreditation may be considered by the CEO or Director of Medical Services for short notice requests, to ensure continuity and safety of care for Patients and/or to meet Organisational Need.
- (b) As a minimum, the following is required:
 - (i) verification of identity through inspection of relevant documents (eg driver's licence with photograph);
 - (ii) contact as soon as practicable 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;
 - (iii) verification of professional registration and insurance as soon as practicable;
 - (iv) confirmation of at least one professional referee of the Medical Practitioner's Competence and good standing;
 - (v) verification will be undertaken by the CEO or Director of Medical Services and will be fully documented.
- (c) Emergency Accreditation will be followed as soon as practicable with Temporary Accreditation or initial Accreditation processes, if required.
- (d) Emergency Accreditation will be approved for a limited period as identified by the CEO or Director of Medical Services, for the safety of Patients involved, and will automatically terminate at the expiry of that period or as otherwise determined by the CEO or Director of Medical Services.
- (e) The Medical Advisory Committee will be informed of all Emergency Accreditation granted.
- (f) There will be no right of appeal from decisions on granting, or termination, of Emergency Accreditation.

9.3 Locum Tenens

Locums must be approved by the Board before they are permitted to arrange the admission of and/or to treat Patients on behalf of Medical Practitioners.

Temporary Accreditation requirements must be met before approval of locums is granted.

There will be no right of appeal from decisions in relation to locum appointments.

10. Variation of Accreditation or Scope of Practice

10.1 Practitioner may request amendment of Accreditation or Scope of Practice

- (a) An Accredited Medical Practitioner may apply for an amendment or variation of their existing Scope of Practice or any term or condition of their Accreditation, other than in relation to the general terms and conditions applying to all Accredited Practitioners as provided in these By-laws.
- (b) The process for amendment or variation is the same for an application for Re-Accreditation, except the Medical Practitioner will be required to complete a Request for Amendment of Accreditation or Scope of Practice Form and provide relevant documentation and references in support of the amendment or variation.
- (c) The process to adopt in consideration of the application for amendment or variation will be as set out in By-laws 8.1 to 8.3.
- (d) The rights of appeal conferred upon Medical Practitioners who apply for amendment or variation are set out in these By-laws, except an appeal is not available for an application made during a probationary period, or in relation to Temporary Accreditation, Emergency Accreditation, or a locum tenens.

11. Review of Accreditation or Scope of Practice

11.1 Board may initiate review of Accreditation or Scope of Practice

- (a) The Board may at any time initiate a review of a Medical Practitioner's Accreditation or Scope of Practice where concerns or an allegation are raised about any of the following:
 - (i) Patient health or safety has been, or could potentially be, compromised;
 - (ii) the rights or interests of a Patient, staff or someone engaged in or at the Facility has been, or could potentially be, adversely affected or infringed upon;
 - (iii) the Medical Practitioner's behaviour;
 - (iv) the Medical Practitioner's level of Competence;
 - (v) the Medical Practitioner's Current Fitness;
 - (vi) the Medical Practitioner's Performance;
 - (vii) compatibility with Organisational Capability or Organisational Need;
 - (viii) the current Scope of Practice granted does not support the care or treatment sought to be undertaken by the Medical Practitioner;
 - (ix) confidence held in the Medical Practitioner;
 - (x) compliance with these By-laws, including terms and conditions, or a possible ground for suspension or termination of Accreditation may have occurred;

- (xi) the efficient operation of the Facility could be threatened or disrupted, the potential loss of the Facility's licence or accreditation, or the potential to bring the Facility into disrepute;
 - (xii) a breach of a legislative or legal obligation of the Facility or imposed upon the Accredited Practitioner may have occurred; or
 - (xiii) as elsewhere defined in these By-laws.
- (b) A review may be requested by any other person or organisation, including external to the Facility, however the commencement of a review remains within the sole discretion of the Board.
- (c) The Board on advice from the CEO will determine whether the process to be adopted is an:
 - (i) Internal Review; or
 - (ii) External Review.
- (d) Prior to determining whether an Internal Review or External Review will be conducted, the CEO may in his or her absolute discretion meet with the Medical Practitioner (the Medical Practitioner may choose to bring along a support person), along with any other persons the CEO considers appropriate, advise of the concern or allegation raised, and invite a preliminary response from the Medical Practitioner (in writing or orally, as determined by the CEO) before the Board makes a determination whether a review will proceed, and if so, the type of review.
- (e) The Accredited Practitioner who is the subject of a review:
 - I. Will ordinarily be offered an opportunity to make a written submission to the reviewers and offered an opportunity to attend before the reviewers to speak to the matters contained in the written submission and any other matters the Accredited Practitioner wishes to address; and
 - II. Must cooperate with reviewers, including providing information reasonably required to inform the review, failing which the Board may make a determination to immediately proceed to suspension or termination of Accreditation.
- (f) As the terms of reference, process, access to information and reviewers are within the complete discretion and determination of the Board, any deviations from the established process will not result in a flawed process and appropriate actions and response to deviations will be as determined by the Board.
- (g) The review may have wider terms of reference than a review of the Medical Practitioner's Accreditation or Scope of Practice.
- (h) The Board must make a determination whether to impose an interim suspension or conditions upon the Accreditation of the Medical Practitioner pending the outcome of the review. There is no right of appeal available from a decision to impose an interim suspension or conditions.
- (i) In addition or as an alternative to conducting an internal or external review, the CEO or Board will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised if required by legislation, otherwise the Board may elect to notify if the Board considers it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, 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 Board may elect to take action, or further action, under these By-laws.

11.2 Internal Review of Accreditation and Scope of Practice

- (a) The CEO will draft the terms of reference of the Internal Review, and may seek assistance from the Medical Advisory Committee or co-opted Medical Practitioners or personnel from within the Facility who bring specific expertise to the Internal Review as determined by the CEO.
- (b) The terms of reference, process, access to information and reviewer(s) will be as recommended by the CEO and determined by the Board. The process will ordinarily include the opportunity to make a written submission to the reviewer(s), an opportunity to attend before the reviewer(s) to speak to the matters contained in the written submission and any other matters the Accredited Practitioner wishes to address including but not limited to responding to the issues of concern, and the opportunity for review of relevant material or a summary of relevant aspects of that material in order to respond.
- (c) The CEO will notify the Medical Practitioner in writing of the review, the terms of reference, process, material to be provided and reviewer(s).
- (d) A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewer(s) to the CEO and Board.
- (e) Following consideration of the report, the Board is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate a Medical Practitioner's Accreditation in accordance with these By-laws.
- (f) The Board must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
- (g) The Medical Practitioner shall have the rights of appeal established by these By-laws in relation to the final determination made by the Board if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.
- (h) In addition or as an alternative to taking action in relation to the Accreditation following receipt of the report, the Board will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation, otherwise the Board may elect to notify if the Board considers it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, 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 Facility.

11.3 External Review of Accreditation and scope of practice

- (a) The Board will make a determination about whether an External Review will be undertaken.
- (b) An External Review will be undertaken by a person(s) external to the Facility and of the Accredited Medical Practitioner in question and such person(s) will be nominated by the Board at its discretion.
- (c) The terms of reference, process, access to information and reviewer(s) will be as recommended by the CEO and determined by the Board. The process will ordinarily include the opportunity to make a written submission to the reviewer(s), an opportunity to attend before the reviewer(s) to speak to the matters contained in the written submission and any other matters the Accredited Practitioner wishes to address including but not limited to responding to the issues of concern, and the opportunity for review of relevant material or a summary of relevant aspects of that material in order to respond.
- (d) The CEO will notify the Medical Practitioner in writing of the review, the terms of reference, process, material to be provided and reviewer(s).

- (e) 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 CEO and Board.
- (f) The Board will review the report and make a determination of whether to continue (including with conditions), amend, suspend or terminate the Medical Practitioner's Accreditation or Scope of Practice in accordance with these By-laws.
- (g) The Board must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
- (h) The Medical Practitioner shall have the rights of appeal established by these By-laws in relation to the final determination made by the Board if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.
- (i) In addition or as an alternative to taking action in relation to the Accreditation following receipt of the report, the Board will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation, otherwise the Board may elect to notify if the Board considers it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, 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 Facility.

12. Suspension, termination, imposition of conditions, resignation and expiry of Accreditation

12.1 Suspension of Accreditation

- (a) The CEO may immediately suspend a Medical Practitioner's Accreditation for a maximum of 5 working days with an extension of same being subject to a Board resolution should the CEO believe, or have a sufficient concern:
 - (i) 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 or health complaints body (including the Office of Health Ombudsman), and may be related to a patient or patients at another facility not operated by the Facility;
 - (ii) the continuance of the current Scope of Practice raises a significant concern about the safety and quality of health care to be provided by the Medical Practitioner;
 - (iii) it is in the interests of staff welfare or safety;
 - (iv) serious and unresolved allegations have been made in relation to the Medical Practitioner. This may be related to a patient or patients of another facility not operated by the Facility, including if these are the subject of review by an external agency including a registration board, disciplinary body, Coroner or a health complaints body (including the Office of Health Ombudsman);
 - (v) the Medical Practitioner fails to observe the terms and conditions of his/her Accreditation;
 - (vi) the behaviour or conduct is in breach of a direction or an undertaking, or the Facility By-laws, code of conduct, policies or procedures;
 - (vii) the behaviour or conduct is such that it is unduly hindering the efficient operation of the Facility at any time, or is bringing the Facility into disrepute;
 - (viii) the behaviour or conduct is considered disruptive or a Behavioural Sentinel Event;

- (ix) the behaviour or conduct of the Medical Practitioner is inconsistent with the values of the Facility;
 - (x) the Medical Practitioner has been suspended by their registration board;
 - (xi) there is a finding of professional misconduct, unprofessional conduct, unsatisfactory professional conduct or some other adverse professional finding (however described) by a registration board or other relevant disciplinary body or professional standards organisation for the Medical Practitioner;
 - (xii) the Medical Practitioner's professional registration is amended, limited, or conditions imposed, or undertakings agreed, irrespective of whether this relates to a current or former Patient of the Facility;
 - (xiii) the Medical Practitioner has made a false declaration or provided false or inaccurate information to the Facility, either through omission of important information or inclusion of false or inaccurate information;
 - (xiv) the Medical Practitioner fails to make the required notifications required to be given pursuant to these By-laws or based upon the information contained in a notification suspension is considered appropriate;
 - (xv) the Accreditation, clinical privileges or Scope of Practice of the Medical Practitioner has been suspended, terminated, reviewed, restricted or made conditional by another health care organisation;
 - (xvi) the Medical 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 Scope of Practice safely and competently and with the confidence of the Facility and the broader community;
 - (xvii) the Medical Practitioner has been convicted of a crime which could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Facility and the broader community;
 - (xviii) 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;
 - (xix) an Internal Review or External Review has been initiated pursuant to these By-laws and the Board considers that an interim suspension is appropriate pending the outcome of the review; or
 - (xx) there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for suspension.
- (b) The CEO shall notify the Medical Practitioner of:
- (i) the fact of the suspension;
 - (ii) the period of suspension;
 - (iii) the reasons for the suspension;
 - (iv) if the Board considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider the suspension should be lifted;
 - (v) if the Board considers it applicable and appropriate in the circumstances, any actions that must be performed for the suspension to be lifted and the period within which those actions must be completed; and

- (vi) the right of appeal, the appeal process and the time frame for an appeal.
- (c) As an alternative to an immediate suspension, the CEO may elect to deliver a show cause notice to the Medical Practitioner advising of:
 - (i) the facts and circumstances forming the basis for possible suspension;
 - (ii) the grounds under the By-laws upon which suspension may occur;
 - (iii) invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider suspension is not appropriate;
 - (iv) if applicable and appropriate in the circumstances, any actions that must be performed for the suspension not to occur and the period within which those actions must be completed; and
 - (v) a timeframe in which a response is required from the Medical Practitioner to the show cause notice;

Following receipt of the response the Board will determine whether the Accreditation will be suspended. If suspension is to occur notification will be sent in accordance with paragraph (b). Otherwise the Medical Practitioner will be advised that suspension will not occur, however this will not prevent the Board from taking other action at this time, including imposition of conditions, and will not prevent the Board from relying upon these matters as a ground for suspension or termination in the future.

- (d) Ordinarily suspension will be suspension of Accreditation in its entirety, however the Board may determine for a particular case that the suspension will be a specified part of the Scope of Practice previously granted and these By-laws in relation to suspension will apply to the specified part of the Scope of Practice that is suspended.
- (e) The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by the Board.
- (f) The affected Medical Practitioner shall have the rights of appeal established by these By-laws.
- (g) The Board will notify the Medical Advisory Committee of any suspension of Accreditation.
- (h) If there is held, in good faith, a belief that the matters forming the grounds for suspension give rise to a significant concern about the safety and quality of health care provided by the Medical Practitioner including but not limited to patients outside of the Facility, it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, it is required by legislation, or for other reasonable grounds, the CEO or Board will notify the Medical Practitioner's registration board and/or other relevant regulatory agency of the suspension and the reasons for it.

12.2 Termination of Accreditation

- (a) Accreditation shall be immediately terminated by the Board if the following has occurred, or if it appears based upon the information available to the Board the following has occurred:
 - (i) the Medical Practitioner ceases to be registered with their relevant registration board;
 - (ii) the Medical Practitioner ceases to maintain Adequate Professional Indemnity Insurance covering the Scope of Practice;
 - (iii) 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; or

- (iv) a contract of employment or to provide services is terminated or ends, and is not renewed.
- (b) Accreditation may be terminated by the Board, if the following has occurred, or if it appears based upon the information available to the Board the following has occurred:
 - (i) based upon any of the matters in By-law 12.1 (a) and it is considered suspension is an insufficient response in the circumstances;
 - (ii) based upon a finalised Internal Review or External Review pursuant to these By-laws and termination of Accreditation is considered appropriate in the circumstances or in circumstances where the Board does not have confidence in the continued appointment of the Medical Practitioner;
 - (iii) the Medical Practitioner is not regarded by the Board as having the appropriate Current Fitness to retain Accreditation or the Scope of Practice, or the Board does not have confidence in the continued appointment of the Medical Practitioner;
 - (iv) conditions have been imposed by the Medical Practitioner's registration board on clinical practice that restricts practice and the Facility does not consider that it has the capacity to accommodate the conditions imposed;
 - (v) the Medical Practitioner has not exercised Accreditation or utilised the facilities at the Facility for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Medical Practitioner by the Board;
 - (vi) the Scope of Practice is no longer supported by Organisational Capability or Organisational Need;
 - (vii) the Medical Practitioner becomes permanently incapable of performing his/her duties which shall for the purposes of these By-laws be a continuous period of six months' incapacity; or
 - (viii) there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for termination.
- (c) The Accreditation of a Medical Practitioner may be terminated as otherwise provided in these By-laws.
- (d) The Board shall notify the Medical Practitioner of:
 - (i) the fact of the termination;
 - (ii) the reasons for the termination;
 - (iii) if the Board considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner why they may consider a termination should not have occurred; and
 - (iv) if a right of appeal is available in the circumstances, the right of appeal, the appeal process and the time frame for an appeal.
- (e) As an alternative to an immediate termination, the Board may elect to deliver a show cause notice to the Medical Practitioner advising of:
 - (i) the facts and circumstances forming the basis for possible termination;
 - (ii) the grounds under the By-laws upon which termination may occur;
 - (iii) invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider termination is not appropriate;

- (iv) if applicable and appropriate in the circumstances, any actions that must be performed for the termination not to occur and the period within which those actions must be completed; and
- (v) a timeframe in which a response is required from the Medical Practitioner to the show cause notice;

Following receipt of the response the Board will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with paragraph (d). Otherwise the Medical Practitioner will be advised that termination will not occur, however this will not prevent the Board from taking other action at this time, including imposition of conditions, and will not prevent the Board from relying upon these matters as a ground for suspension or termination in the future.

- (f) All terminations must be notified to the Medical Advisory Committee.
- (g) For a termination of Accreditation pursuant to By-law 12.2(a), there shall be no right of appeal.
- (h) For a termination of Accreditation pursuant to By-law 12.2(b), the Medical Practitioner shall have the rights of appeal established by these By-laws.
- (i) Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by the Board to the Medical Practitioner's registration board and/or other relevant regulatory agency.

12.3 Imposition of conditions

- (a) At the conclusion of or pending finalisation of an Internal or External Review, or in lieu of a suspension, or in lieu of a termination, the Board may elect to impose conditions on the Accreditation or Scope of Practice.
- (b) The Board must notify the Medical 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.
- (c) If the Board considers it applicable and appropriate in the circumstances, they may also invite a written response from the Medical Practitioner as to why the Medical Practitioner may consider the conditions should not be imposed.
- (d) If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Board.
- (e) The affected Medical Practitioner shall have the rights of appeal established by these By-laws.
- (f) 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 CEO/Board will notify the Medical Practitioner's registration board and/or other relevant regulatory agency of the imposition of the conditions and the reasons the conditions were imposed.

12.4 Resignation and expiry of Accreditation

A Medical Practitioner may resign his/her Accreditation by giving one month's notice of the intention to do so to the CEO, unless a shorter notice period is otherwise agreed by the CEO.

A Medical Practitioner who intends to cease treating Patients either indefinitely or for an extended period must notify his/her intention to the CEO, and Accreditation will be taken to be withdrawn one month from the date of notification unless the CEO decides a shorter notice period is appropriate in the circumstances.

If an application for Re-Accreditation is not received within the timeframe provided for in these By-laws, unless determined otherwise by the CEO, the Accreditation will expire at the conclusion of its term. If the Medical Practitioner wishes to admit or treat Patients at the Facility after the expiration of Accreditation, an application for Accreditation must be made as an application for initial Accreditation.

If the Medical Practitioner's Scope of Practice is no longer supported by Organisational Capability or Organisational Need, if the Medical 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 Facility is regarded by the CEO to be insufficient, the CEO will raise these matters in writing with the Accredited Practitioner and invite a meeting to discuss. Following the meeting the CEO 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 Medical Practitioner wishes to admit or treat Patients at the Facility, an application for Accreditation must be made as an application for initial Accreditation.

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

13. Appeal rights and procedure

13.1 Rights of appeal against decisions affecting Accreditation

- (a) There shall be no right of appeal against a decision to not approve initial Accreditation, Temporary Accreditation, Emergency Accreditation, a locum appointment, or continued Accreditation at the end of a probationary period or Temporary Accreditation, Emergency Accreditation or locum period, or for matters specified elsewhere in these By-Laws that there will be no right of appeal.
- (b) Subject to paragraph a) above, a Medical Practitioner shall have the rights of appeal as set out in these By-laws.

13.2 Appeal process

- (a) A Medical Practitioner shall have fourteen (14) days from the date of notification of a decision to which there is a right of appeal in these By-laws to lodge an appeal against the decision.
- (b) An appeal must be in writing to the CEO and received by the CEO within the fourteen (14) day appeal period or else the right to appeal is lost.
- (c) Unless decided otherwise by the Board 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 and be actioned accordingly.
- (d) Upon receipt of an appeal notice the CEO will immediately forward the appeal request to the chairperson of the Board.
- (e) The chairperson of the Board will nominate an Appeal Committee to hear the appeal, establish terms of reference, and submit all relevant material to the chairperson of the Appeal Committee.
- (f) The Appeal Committee shall comprise at least three (3) persons and will include:
 - (i) a nominee of the Board, who may be an Accredited Practitioner, who must be independent of the decision under appeal regarding the Medical Practitioner, and who will be the chairperson of the Appeal Committee;

- (ii) a nominee of the CEO, who may be an Accredited Practitioner, and who must be independent of the decision under appeal regarding the Medical Practitioner;
 - (iii) any other member or members who bring specific expertise to the decision under appeal, as determined by the chairperson of the Board, who must be independent of the decision under appeal regarding the Medical Practitioner, and who may be an Accredited Practitioner. The chairperson of the Board in their complete discretion may invite the appellant to make suggestions or comments on the proposed additional members of the Appeal Committee (other than the nominees in (i) and (ii) above), but is not bound to follow the suggestions or comments.
- (g) Before accepting the appointment, the nominees will confirm that they do not have a known conflict of interest with the appellant and will sign a confidentiality agreement. Once all members of the Appeal Committee have accepted the appointment, the chairperson of the Board will notify the appellant of the members of the Appeal Committee.
 - (h) Unless a shorter timeframe is agreed by the appellant and the Appeal Committee, the appellant shall be provided with at least 14 days notice of the date for determination of the appeal by the Appeal Committee. The notice from the Appeal Committee will ordinarily set out the date for determination of the appeal, the members of the Appeal Committee, the process that will be adopted, material to be provided and will invite the appellant to make a submission about the decision under appeal. Subject to an agreement to confidentiality from the appellant, the chairperson of the Appeal Committee may provide the appellant with copies of material to be relied upon by the Appeal Committee, or alternatively, may decide that it is in the circumstances it is more appropriate to provide relevant excerpts from material or a summary.
 - (i) The appellant will be given the opportunity to make a submission to the Appeal Committee, including with respect to the issues of concern and action taken with respect to those issues of concern. The Appeal Committee shall determine whether the submission by the appellant may be in writing or in person or both.
 - (j) 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 submission will be provided within 7 days of the request.
 - (k) The CEO (or nominee) may present to the Appeals Committee in order to support the decision under appeal.
 - (l) If the appellant attends before the Appeal Committee to answer questions and to make submissions, 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, unless the Appeal Committee decides otherwise.
 - (m) The appellant shall not be present during Appeal Committee deliberations except when invited to be heard in respect of his/her appeal.
 - (n) The chairperson of the Appeal Committee shall determine any question of process and procedure for the appeal and Appeal Committee, with questions of process and procedure entirely within the discretion of the chairperson of the Appeal Committee, subject to the requirement to act in accordance with the established terms of reference. Any deviations by the Appeal Committee from the established process will not result in a flawed process and appropriate actions and response to deviations will be as determined by the chairperson of the Appeal Committee.

- (o) The Appeal Committee will make a written recommendation regarding the appeal to the chairperson of the Board, including provision of reasons for the recommendation. The recommendation may be made by a majority of the members of the Appeal Committee and if an even number of Appeal Committee members then the chairperson of the Appeal Committee has the deciding vote. A copy of the recommendation will be provided to the CEO and appellant.
- (p) The Board will consider the recommendation of the Appeal Committee and make a decision about the appeal.
- (q) The decision of the Board will be notified in writing to the CEO and appellant.
- (r) The decision of the Board is final and binding, and there is no further appeal allowed under these By-laws from this decision.
- (s) If a notification has already been given to an external agency, such as a registration Board, then the Board will notify that external agency of the appeal decision. If a notification has not already been given, the Board 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.

Part D – Accreditation of Dentists

14. Accreditation and Scope of Practice of Dentists

By-laws 7 to 13 are hereby repeated in full substituting where applicable Dentist for Medical Practitioner.

Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the CEO.

Part E– Accreditation of Visiting Allied Health Professionals

15. Accreditation and Scope of Practice of Visiting Allied Health Professionals and Visiting Registered Nurses (not employed by Mater Health Services North Queensland Ltd)

By-laws 7 to 13 are hereby repeated in full substituting where applicable Allied Health Professional or Registered Nurses for Medical Practitioner.

This By-law 15 may also be utilised for other health practitioners who do not fall into the category of Medical Practitioner, Dentist or Allied Health Professional, with the process as modified by the CEO to suit the particular circumstances of the case.

Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the CEO.

Part F – Amending By-laws, annexures, and associated policies and procedures, and other matters

16. Amendments to, and instruments created pursuant to, the By-laws

- (a) Amendments to these By-laws can only be made by approval of the Board.
- (b) All Accredited Practitioners will be bound by amendments to the By-laws from the date of approval of the amendments by the Board, even if Accreditation was obtained prior to the amendments being made.
- (c) The Board may approve any annexures that accompany these By-laws, and amendments that may be made from time to time to those annexures, and the annexures once approved by the Board are integrated with and form part of the By-laws. The documents contained in the annexures must be utilised and are intended to create consistency in the application of the processes for Accreditation and granting of Scope of Practice.
- (d) The Board may approve forms, terms of reference and policies and procedures 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 Scope of Practice requirements and the further criteria and requirements will be incorporated as criteria and requirements of these By-laws.

17. Audit and Compliance

The CEO will establish a regular audit process, at intervals determined to be appropriate by the CEO or as may be required by a regulatory authority, to ensure compliance with the processes set out in these By-laws relating to Credentialing and Accreditation, and any associated policies and procedures.

The audit process will include identification of opportunities for quality improvement in the Credentialing and Accreditation processes that will be reported to the Board by the CEO.

Annexure - A

Model Criteria for Each Accreditation Category

Model Criteria for Each Accreditation Category

Type of Appointment	Details
Accredited Practitioners	
Specialist Practitioner & Staff Specialist	<ul style="list-style-type: none"> • Specialist in an Australian Fellowship or equivalent; recognised under the Health Insurance Act 1973 as a specialist. • May admit and treat patients within the terms of their Clinical Privileges. • Responsible for the clinical care of their in-patients. • Participates in continuing education activities of the Hospital.
General Practitioner	<ul style="list-style-type: none"> • FRACGP or equivalent. • May admit and treat patients within the terms of their Clinical Privileges in accordance with MHSNQ Policy. • Responsible for the clinical care of their in-patients. • Participates in continuing education activities of the Hospital.
Clinical Fellowships Training Registrars/Interns/Resident Medical Officers	<ul style="list-style-type: none"> • Specialist in Training to gain subspecialty qualifications and experience of the relevant Specialist Medical/Surgical College. • May admit and treat patients under the supervision of and/or on behalf of the Sponsoring VMO, within the terms of their and their Sponsor's Clinical Privileges. • Responsible for the clinical care of in-patients, as they may initiate on behalf of the Sponsoring VMO. • May participate in continuing education activities of the Hospital.
Surgical Assistant Medical (specialty) No admitting rights	<ul style="list-style-type: none"> • General Practitioner or Specialist Practitioner with Australian Fellowship or equivalent. • May not admit and/or treat patients, but may assist in theatres and visit patients in the ward areas, examine medical records for their patients, but not initiate or change treatment orders. • Credentialing Committee may limit Clinical Privileges of theatre assistant role to a particular specialty or surgeon.
In-house Medical Officer	<ul style="list-style-type: none"> • Provide ward-based care to in-patients admitted by Specialist Practitioners on behalf of, and under the direction of, the Specialist Practitioner or Staff Specialist. • No admitting rights, except for initial emergent or urgent admission on behalf of the admitting Specialist Practitioner or Staff Specialist. • Participate in continuing education activities of the Hospital.
Dentist	<ul style="list-style-type: none"> • Dentists who may admit and treat dental in-patients (usually day only patients requiring operating theatre procedures) within the terms of their Clinical Privileges. • Participates in continuing education activities of the Hospital. • Responsible for the clinical care of their patients.
Consultant Emeritus	<ul style="list-style-type: none"> • Medical Practitioner or Dentist who has provided distinguished services 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 and is awarded this title, in a combined decision by the Hospital Executive and MACC.
Surgical Assistant (Non-Medical)	<ul style="list-style-type: none"> • Must provide evidence of training in approved Surgical Assistant course.
University Student	<ul style="list-style-type: none"> • Arrangement with University (organisational policy).

Annexure - B

Model Criteria for the Delineation of Clinical Privileges

The model criteria are the primary fields of Clinical Privileges in Mater Health Services NQ Ltd. The model criteria are for guidance in relation to categories that need to be taken into account regarding Credentials and Clinical Privileges. There may be occasions where practitioners are not listed in the categories below.

For the purpose of this Annexure B, reference to a neonate is reference to a newborn child aged day zero to one month and use of the term paediatric refers to a child not more than 15 years of age. All other persons are classified as adults.

IMPORTANT NOTE: *All Accredited Practitioners with Clinical Privileges must be able to demonstrate participation in programs to maintain and improve the quality of care they give to patients, so as to guarantee the highest possible standards of care to the community, including but not limited to, participation in recognised quality improvement activities, recognised continuing medical education and professional development activities. Accredited Practitioners must also be able to confirm that they undertake regular work of an appropriate volume and complexity as is necessary to maintain proper clinical standards of practice in the fields in which they have Clinical Privileges.*

- | | | |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Allied Health | <input type="checkbox"/> Dental Practitioner | <input type="checkbox"/> Paediatric Medicine |
| <input type="checkbox"/> Dietitian | <input type="checkbox"/> Dermatology | <input type="checkbox"/> Paediatric Surgery |
| <input type="checkbox"/> Electrophysiologist | <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Pain Medicine |
| <input type="checkbox"/> Exercise Physiology | <input type="checkbox"/> ENT Surgery | <input type="checkbox"/> Palliative Medicine |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Orthotist / Prosthetist | <input type="checkbox"/> Endoscopic Ultrasound | <input type="checkbox"/> Anatomical |
| <input type="checkbox"/> Other | <input type="checkbox"/> ERCP | <input type="checkbox"/> Biochemistry |
| <input type="checkbox"/> Perfusion | <input type="checkbox"/> Other | <input type="checkbox"/> Laboratory Haematology |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> General Medicine | <input type="checkbox"/> Microbiology |
| <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Plastic & Reconstructive Surgery |
| <input type="checkbox"/> Podiatry | <input type="checkbox"/> <input type="checkbox"/> General Surgery | <input type="checkbox"/> <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Psychology | <input type="checkbox"/> Adult | <input type="checkbox"/> Sub-Specialty |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Bariatric | <input type="checkbox"/> <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Speech Pathology | <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Interventional (Tier B) |
| | <input type="checkbox"/> Other | <input type="checkbox"/> Non-Interventional (Tier A) |
| | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> <input type="checkbox"/> Anaesthesia | <input type="checkbox"/> Gynaecological Oncology | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Adult | <input type="checkbox"/> Gynaecology | <input type="checkbox"/> Rehabilitation Medicine |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Haematology | <input type="checkbox"/> Respiratory & Sleep Medicine |
| <input type="checkbox"/> Medical Perfusion | <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Obstetric | <input type="checkbox"/> Intensive Care Medicine | <input type="checkbox"/> Surgical Assistant |
| <input type="checkbox"/> Paediatric | <input type="checkbox"/> Medical Officer in ICU | <input type="checkbox"/> Urogynaecology |
| <input type="checkbox"/> <input type="checkbox"/> Cardiology | <input type="checkbox"/> Medical Oncology | <input type="checkbox"/> <input type="checkbox"/> Urology |
| <input type="checkbox"/> Diagnostic Procedures | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Vascular Surgery |
| <input type="checkbox"/> Endovascular Procedures | <input type="checkbox"/> Neurology | |
| <input type="checkbox"/> EPS | <input type="checkbox"/> Neurosurgery | |
| <input type="checkbox"/> Implantable Electronic Devices | <input type="checkbox"/> Nuclear Medicine | |
| <input type="checkbox"/> Interventional Procedures | <input type="checkbox"/> Obstetrics | |
| <input type="checkbox"/> Paediatric Procedures | <input type="checkbox"/> <input type="checkbox"/> Ophthalmology | |
| <input type="checkbox"/> Cardiothoracic Surgery | <input type="checkbox"/> Oral Maxillofacial Surgery | |
| <input type="checkbox"/> Dental Assistant | <input type="checkbox"/> <input type="checkbox"/> Orthopaedic Surgery | |

ANAESTHETICS

Anaesthetics (General)	<ul style="list-style-type: none">▪ FANZCA or equivalent▪ Demonstrable competency in special areas such as Cardiac and Neonatal
Anaesthetics (Pain Management)	<ul style="list-style-type: none">▪ FANZCA or equivalent▪ Satisfy ANZCA accreditation guidelines for pain medicine.

CARDIOLOGY

Cardiology	<ul style="list-style-type: none">▪ FRACP or equivalent.
TOE (trans-oesophageal echo-cardiography)	<ul style="list-style-type: none">▪ FRACP or equivalent.
Coronary Angioplasty	<ul style="list-style-type: none">▪ Must satisfy the Accreditation Guidelines of The Cardiac Society of Australia and New Zealand http://www.csanz.edu.au/guidelines/training/Angioplasty_Guidelines.pdf
Diagnostic Cardiac Catheterization and Coronary Angiography	<ul style="list-style-type: none">▪ Must satisfy the Accreditation Guidelines of The Cardiac Society of Australia and New Zealand http://www.csanz.edu.au/guidelines/training/Angiography_Guidelines.pdf
Adult Clinical Cardiac Electrophysiology	<ul style="list-style-type: none">▪ Must satisfy the Accreditation Guidelines of The Cardiac Society of Australia and New Zealand http://www.csanz.edu.au/guidelines/training/Adult_Clinical_Cardiac_Electrophysiology.pdf
Cardiac Implantable Electronic Devices	<ul style="list-style-type: none">▪ Must satisfy the Accreditation Guidelines of The Cardiac Society of Australia and New Zealand http://www.csanz.edu.au/guidelines/training/Cardiac_Implantable_Electronic_Devices.pdf
Adult Echocardiography	<ul style="list-style-type: none">▪ Must satisfy the Accreditation Guidelines of The Cardiac Society of Australia and New Zealand http://www.csanz.edu.au/guidelines/training/Echo_Training_Guidelines_April_2004.pdf

CARDIOTHORACIC SURGERY

Adult	<ul style="list-style-type: none">▪ FRACS (Cardiothoracic Surgery) or equivalent.
Paediatric	<ul style="list-style-type: none">▪ FRACS (Cardiothoracic Surgery) or equivalent.▪ Completion of a recognised formal training program in Paediatric Cardiothoracic Surgery.

DENTAL

General	<ul style="list-style-type: none">▪ BDSc or equivalent.
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DERMATOLOGY

General	<ul style="list-style-type: none">▪ FACD or equivalent.
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ENT SURGERY

ENT Surgery - Adult	<ul style="list-style-type: none">▪ FRACS (Otolaryngology) or equivalent.▪ Demonstrable competency in special areas such as Head & Neck, Paediatric and Paediatric Endoscopic ENT surgery.
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GASTROENTEROLOGY

Gastroenterology	<ul style="list-style-type: none">▪ FRACP or equivalent.
Endoscopy	<ul style="list-style-type: none">▪ Recognition by the Conjoint Committee for Endoscopy Training in Colonoscopy (College of Surgeons, College of Physicians and Gastroenterological Society of Australia) or equivalent.
ERCP (Endoscopic Retrograde Cholangio-Pancreatography)	<ul style="list-style-type: none">▪ FRACP or FRACS or equivalent.

GENERAL PRACTITIONER

	<ul style="list-style-type: none">▪ FRACGP or equivalent.
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GENERAL SURGERY

General Surgery	▪ FRACS or equivalent.
Endoscopy	▪ Recognition by the Conjoint Committee for Endoscopy Training in Colonoscopy (College of Surgeons, College of Physicians and Gastroenterological Society of Australia) or equivalent.
Colorectal Surgery	▪ FRACS or equivalent. ▪ Recognition by the Conjoint Committee for Endoscopy Training in Colonoscopy (College of Surgeons, College of Physicians and Gastroenterological Society of Australia) or equivalent.
Laparoscopic Surgery	▪ Provide evidence of advanced training in Laparoscopic Surgery.

INTENSIVE CARE

Intensive Care	▪ FANZCA (Faculty of Intensive Care) or FRACP or equivalent. ▪ Faculty of Intensive Care Certificate or equivalent. ▪ Where university affiliation applies, current appointment to a Teaching Hospital Intensive Care Unit.
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NEUROSURGERY

Adult	▪ FRACS (Neurosurgery) or equivalent.
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NUCLEAR MEDICINE

	▪ FRACP or equivalent.
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OBSTETRICS AND GYNAECOLOGY

Obstetrics	▪ FRANZCOG or equivalent.
Gynaecology – General	▪ FRANZCOG or equivalent.
Gynaecological Oncology	▪ FRANZCOG/CGO – Certificate in Gynaecological Oncology or equivalent.
Advanced Endoscopic Surgery	▪ FRANZCOG or equivalent. ▪ Provide evidence of completion of recognised formal training in advanced Endoscopic Surgery.

OPHTHALMOLOGY

Adult	▪ FRANZCO ▪ FRANCS, FRACO or equivalent.
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ORAL AND MAXILLOFACIAL SURGERY

Oral and Maxillofacial	▪ FRACDS (OMS) or equivalent.
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ORTHOPAEDICS

Orthopaedic Surgery	▪ FRACS (Orthopaedic Surgery) or equivalent. ▪ Demonstrable competency in: <ul style="list-style-type: none">- Major Joint- Spinal- Hand & Upper Limb- Foot & Ankle- Paediatric
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PAEDIATRIC MEDICINE

General	▪ FRACP (Division of Paediatrics) or equivalent
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PAEDIATRIC SURGERY

Paediatric Surgery	▪ FRACS (Paediatric Surgery) or equivalent.
Paed Upper GI	▪ Recognition by Conjoint Committee
Paed Lower GI	

PALLIATIVE CARE

	▪ FRACP or FANZCA or equivalent.
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PATHOLOGY

General	▪ FRCPA or equivalent.
Microbiology	▪ FRCPA or equivalent.

PHYSICIAN / INTERNAL MEDICINE

Infectious Diseases (IND)	▪ FRACP or FRCPA or equivalent
General Medicine	▪ FRACP or equivalent.
Clinical Haematology	▪ FRCPA or equivalent.
Clinical Oncology (ONC)	▪ FRACP or equivalent
Endocrinology (END)	▪ FRACP or equivalent.
Geriatrics (GER)	▪ FRACP or equivalent.
Neurology (NEU)	▪ FRACP or equivalent.
Renal Medicine (REN)	▪ FRACP or equivalent.
Respiratory Physician	▪ FRACP or equivalent.
Rheumatology (RHE)	▪ FRACP or equivalent.

PLASTIC AND RECONSTRUCTIVE SURGERY

Plastic and Reconstructive Surgery	<ul style="list-style-type: none">▪ FRACS (Plastic Surgery) or FRACS or FRACD (OMS) or equivalent.▪ Demonstrable competency in:<ul style="list-style-type: none">- Hand Surgery- Facio-Maxillary Surgery- Plastic, Reconstructive and Aesthetic Surgery- Head and Neck Surgery
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PSYCHIATRY

	▪ FRANZCP or equivalent.
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RADIATION ONCOLOGY

Radiation Oncology	▪ FRACP or equivalent.
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RADIOLOGY

	<ul style="list-style-type: none">▪ FRACR or equivalent.▪ Those wishing to have interventional rights should have relevant training in the past two (2) years and be supported by three (3) referees who can attest to this recent activity.
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REHABILITATION MEDICINE

General	▪ FAFRM (RACP) or equivalent and demonstrate expertise in the relevant modality.
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UROLOGY

Adult	<ul style="list-style-type: none">▪ FRACS (Urology) or equivalent.▪ Demonstrable competency in<ul style="list-style-type: none">- Lithotripsy- Laser Lithotripsy
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VASCULAR SURGERY

Vascular Surgery	<ul style="list-style-type: none">▪ FRACS (Vascular Surgery) or equivalent, or▪ FRACS or equivalent with completion of a specialty training program in Vascular Surgery.
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ALLIED HEALTH PROFESSIONALS

Chiropractic	A person is entitled to be registered as a Chiropractor if they fulfil the requirements of the relevant State/National Act and hold a diploma, certificate or other equivalent qualification, which is satisfactory to the relevant Regulatory/Licensing body.
Physiotherapy	A person is entitled to be registered as a Physiotherapist if they fulfil the requirements of the relevant State/National Act and hold a degree, diploma or other equivalent qualification, which is satisfactory to the relevant Regulatory/Licensing body.
Podiatry	A person is entitled to be registered as a Podiatrist if they fulfil the requirements of the relevant State/National Act and have completed a course of training and study as determined/recognised by the relevant Regulatory/Licensing body.
Pharmacy	A person is entitled to be registered as a Pharmacist if they fulfil the requirements of the relevant State/National Act and the person holds a degree or its equivalent as approved by the relevant Regulatory/Licensing body.
Speech Pathology	A person is entitled to be registered as a Speech Pathologist if they fulfil the requirements of the relevant State/National Act and Regulating body and hold a degree, diploma or certificate, which is recognised by the relevant Regulatory/Licensing body.
Psychology	A person is entitled to be registered as a Psychologist if they fulfil the requirements of the relevant State/National Act and hold a degree or its equivalent, which is recognised by the relevant Regulatory/Licensing body.
Occupational Therapy	A person is entitled to be registered as an Occupational Therapist if they fulfil the requirements of the relevant State/National Act and hold a degree, diploma or certificate recognised by the relevant Regulatory/Licensing body.
Non-Medical Surgical Assistant	Possess an appropriate post-graduate qualification suitable for Surgical Assistant. Indemnity Insurance Certificate (to be reviewed by Executive Director of Nursing/CEO).

NOTE: A reference to "State/National Act and/or Regulation", in this Annexure B, is a reference to the relevant legislation (as may be amended from time-to-time), which sets out the statutory requirements for healthcare professionals to be registered/licensed

ADDITIONAL CRITERIA FOR APPOINTMENT

1. Appropriate professional fellowship or equivalent.
2. Membership of an appropriate group, society or association or equivalent (where applicable).
3. Specialist recognition (if appropriate).
4.
 - a) Three (3) peer referees who can attest recent practice is consistent with the criteria contained within the By-Laws and are not professionally or financially related to the applicant (refer "Professional Referee Report").
 - b) Such referees should be familiar with the current professional capabilities of the applicant for appointment.
 - c) At least one reference must be the same medical specialty.
5. Any specific criteria for the granting of privileges as adopted by the Hospital from time-to-time.
6. Be a regular attendee at peer review/quality improvement/clinical audit activities as required, and produce evidence on this to the satisfaction of the Credentials Committee/MAC.
7. Any other criteria for appointment, including for example, teaching commitment in association with the Hospital's affiliation to a university medical school.
8. Arranges an appropriate substitute Accredited Practitioner when unavailable and provides adequate notice to the Hospital of transfer of patient care to the substitute Accredited Practitioner.
9. Attending to patients in person with reasonable frequency.