



# **St Andrew's Toowoomba Hospital**

## **By-Laws and Professional Guidelines for Medical Practitioners and Allied Health Professionals**

<i>Document Title: By-Laws and Professional Guidelines for Medical Practitioners and Allied Health Professionals</i>	
<i>Developed By: Chief Executive Officer and Hospital Board of Governors</i>	
<i>Authorised By: Hospital Board of Governors</i>	
<i>Date Developed: 26 June 2002</i>	
<i>Last Reviewed: March 2009</i>	<i>Next Review Due: March 2011</i>

## TABLE OF CONTENTS

1.	Definitions and Interpretation .....	4
2.	Interpretation.....	7
3.	Meetings .....	7
4.	Credentialing and Clinical Privileges Committee .....	8
4.1	Statement of Intent .....	8
4.2	Role of the Credentialing and Clinical Privileges Committee.....	8
4.3	Membership of the Committee.....	9
4.4	Meetings of the Credentialing and Clinical Privileges Committee .....	9
5.	Credentialing and Appointment of Visiting Medical Officers.....	10
5.1	Entitlement to treat Patients at the Hospital .....	10
5.2	Eligibility for Appointment as a Visiting Medical Officer .....	10
5.3	Applications for Appointment as a Visiting Medical Officer.....	10
5.4	Responsibility and Basis for Granting Clinical Privileges.....	11
6.	The Process for Appointing and Re-appointing Visiting Medical Officers .....	11
6.1	Applications for Initial Appointment to the Medical Director .....	11
6.2	Consideration by the Credentialing and Clinical Privileges Committee.....	12
6.3	Consideration of Applications for Appointment as Visiting Medical Officers by the Hospital Board .....	14
6.4	Reappointment .....	15
6.5	Tenure .....	15
6.6	Extraordinary Accreditation.....	16
6.7	Locum Tenens .....	17
7.	Variation of Accreditation or Clinical Privileges .....	17
7.1	Application for Variation .....	17
8.	Review of Accreditation or Clinical Privileges.....	18
8.1	Initiation of Review .....	18
8.2	Internal Review .....	19
8.3	External Review .....	20

---

<b>9.</b>	<b>Suspension, Termination, Imposition of Conditions, Resignation and Expiry of Accreditation.....</b>	<b>21</b>
9.1	Suspension .....	21
9.2	Termination.....	24
9.3	Imposition of Conditions.....	26
9.4	Resignation and Expiry of Accreditation .....	27
<b>10.</b>	<b>Appeals.....</b>	<b>27</b>
10.1	Rights of Appeal .....	27
10.2	Appeal Process.....	28
<b>11.</b>	<b>Accreditation of Visiting Allied Health Professionals .....</b>	<b>30</b>
<b>12.</b>	<b>Ethics and Expectations.....</b>	<b>30</b>
12.1	Compliance with By-Laws.....	30
12.2	Hospital Policies and Procedures .....	30
12.3	Standard of Conduct .....	30
12.4	Insurance and Registration.....	31
12.5	Notifications.....	31
12.6	Continuous Disclosure.....	32
12.7	Representation and Media .....	33
12.8	Committees .....	33
12.9	Confidentiality.....	33
12.10	Admission, Availability, Communication and Discharge.....	34
12.11	Utilisation .....	35
12.12	Informed Consent and Financial Consent .....	35
12.13	Patient Records .....	36
12.14	Financial Information and Statistics.....	36
12.15	Quality Improvement, Risk Management and Regulatory Agencies .....	37
12.16	Research .....	37
12.17	New Clinical Services.....	38
<b>13.</b>	<b>Amendments to By-Laws .....</b>	<b>39</b>

---

---

## St Andrew's Toowoomba Hospital

### By-Laws and Professional Guidelines for Medical Practitioners and Allied Health Professionals

#### PART 1 – DEFINITIONS AND INTERPRETATION

##### 1. Definitions and Interpretation

In the By-Laws, unless indicated to the contrary:

**“Accreditation”** means the process provided in these By-Laws by which a Medical Practitioner or Allied Health Professional is Accredited, with **“Re-Accreditation”** the process by which a person who already holds Accreditation may apply for and be considered for a further period of Accreditation at the Hospital.

**“Accredited”** means the status conferred on a Medical Practitioner or Allied Health Professional to provide services at the Hospital after having satisfied the Credentialing requirements provided in these By-laws.

**“Accredited Practitioner”** means a Medical Practitioner or Allied Health Professional who has been Accredited to provide services at the Hospital and who may be an **“Visiting Medical Officer”** or **“Visiting Allied Health Professional”**

**“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 Hospital Board and is in an amount and on terms that the Hospital Board considers in their absolute discretion to be sufficient. The insurance must be adequate for the Clinical Privileges.

**“Allied Health Privileges”** means the entitlement to provide treatment and care to Patients as a Visiting Allied Health Professional within the areas approved by the Hospital Board in accordance with the provisions of the By-Laws and in the case of Dentists, may be granted with or without admitting rights.

**“Allied Health Professional”** means a Dentist or other person registered under the appropriate legislation to practise as an Allied Health Professional in the State of Queensland, or other categories of appropriately qualified health professionals as approved by the Hospital Board.

**“Allied Health Professionals Register”** means the Hospital's register of Visiting Allied Health Professionals.

**“Appointment”** means the formal process of granting an applicant for appointment as a Visiting Medical Officer or a Visiting Allied Health Professional the right to be a Visiting Medical Officer or a Visiting Allied Health Professional and establishing the Clinical Privileges, as the case may be, to be granted to the applicant.

**"By-Laws"** means these By-Laws.

**"Chairman"** means the Chairman of the Hospital Board.

**"Chief Executive Officer"** means the Chief Executive Officer of the Hospital and any person acting, or delegated to act, in that position.

**"Clinical Privileges"** means the entitlement to admit Patients to the Hospital and provide medical care and treatment to Patients, or provide medical or other care and treatment to Patients already admitted to the Hospital, within the defined scope of practice approved by the Hospital Board in accordance with the provisions of the By-Laws, and may be Visiting Medical Officer Privileges for Visiting Medical Officers and Allied Health Privileges for Allied Health Professionals.

**"Competence"** means, in respect of a person who applies for Appointment as a Visiting Medical Officer or Visiting Allied Health Professional, that the person is possessed of the necessary aptitude in the application of knowledge and skills in interpersonal relationships, decision making and the performance necessary for the Clinical Privileges for which the applicant has applied and has the demonstrated ability to provide health care 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 experience in leadership, research, education, communication and teamwork that contribute to the person's Competence and professional suitability to provide safe, high quality health care services. The history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal record are relevant to the Credentials.

**"Credentialing"** means, in respect of a person who applies for Accreditation, the formal process used to verify and assess the education, qualifications, experience, clinical outcomes, professional standing and memberships, registration, professional indemnity history and status, references, and other relevant professional attributes of the applicant for the purpose of forming a view about their Credentials, Competence, and professional suitability to provide, safe, competent, ethical and high quality health care services at the Hospital within the defined Clinical Privileges granted. The process of Credentialing will take into account Organisational Capability and Organisational Need.

**"Credentialing and Clinical Privileges Committee"** means the Credentialing and Clinical Privileges Committee for the Hospital established under these By-Laws.

**"Current Fitness"** is the fitness required of an applicant for Accreditation to carry out the Clinical Privileges sought or currently held. A person is not to be considered as having current fitness if that person suffers from 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 carry out the Clinical Privileges.

**"Dentist"** means persons registered pursuant to the *Dental Practitioners Registration Act 2001* (Qld) to practise dentistry in the State of Queensland.

---

**“Director of Clinical Services”** means the Director of Clinical Services of the Hospital and any person acting, or delegated to act, in that position.

**"Hospital "** means St Andrew's Toowoomba Hospital.

**"Hospital Board"** means the St Andrew's Toowoomba Hospital Board of Governors appointed by the Assembly of the Presbyterian Church of Queensland.

**"Medical Director"** means the Medical Director of the Hospital and any person acting, or delegated to act, in that position.

**"Medical Practitioner"** means a person registered under the provisions of the *Medical Practitioners Registration Act 2001* (Qld) to practise medicine in the State of Queensland.

**"Medical Register"** means the Hospital's register of Visiting Medical Officers.

**“New Clinical Services”** means clinical services, treatment, procedures, techniques, technology, instruments or other interventions that are being introduced into the organisational setting of the Hospital for the first time, or if currently used are planned to be used in a different way.

**“Organisational Capability”** means the Hospital's ability to provide the facilities, services and clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational Capability will be determined by consideration of the availability, limitations and/or restrictions of the services, staffing, facilities, equipment, and support services required and with reference to the Clinical Services Plan of the Hospital and the Queensland Health Clinical Services Capability Framework.

**“Organisational Need”** means the extent to which the Hospital is required 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. Organisational Need will be determined by the strategic direction of the Hospital, Clinical Services Plan, business and operational plans of the Hospital and the Queensland Health Clinical Services Capability Framework

**“Patient”** means a person admitted to, or treated as an outpatient at, the Hospital.

**"Principal Practitioner"** means a Visiting Medical Officer who admits a Patient and is primarily responsible for that Patient during the term of that Patient's admission to the Hospital.

**"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 has received specialist registration in Queensland.

**"Visiting Allied Health Professional"** means any Allied Health Professional or Dentist, who is not an employee of the Hospital, and who has been granted Visiting Allied Health Privileges pursuant to the By-Laws.

---

**"Visiting Medical Officer"** means a Medical Practitioner, who is not an employee of the Hospital, and who has been granted Visiting Medical Officer Privileges pursuant to the By-Laws. A Visiting Medical Officer may include a Specialist Medical Practitioner.

**"Visiting Medical Officer Privileges"** means the entitlement to provide treatment and care to Patients as a Visiting Medical Officer within the areas approved by the Hospital Board in accordance with the provisions of the By-Laws, and may be granted with or without admitting rights.

## 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, and reference to legislation (including subordinate legislation or regulation) is to that legislation as amended, re-enacted or replaced.

The Hospital Board may delegate any of the responsibilities conferred upon it by the By-Laws in their complete discretion.

The Chief Executive Officer 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 Hospital Board.

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

## 3. **Meetings**

Where a reference is made to a meeting, the quorum requirements that will apply are those specified in the terms of reference approved by the Hospital Board.

Resolutions and decisions, if not specified in the terms of reference, must be supported by a show of hands or ballot of 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 to any third party or beyond the purpose for which the information was made available.

A member of a committee who has a conflict of interest in a matter to be decided or discussed shall inform the chairperson of the committee prior to any discussion commencing and will take no part in any relevant discussion or resolution with respect to that particular matter and shall absent themselves from the room during discussions about the matter. The determination of a conflict of interest, if required, will be made by the Chairman or the Hospital Board, with that determination final and binding.

## **PART 2 – CREDENTIALING AND CLINICAL PRIVILEGES COMMITTEE**

### **4. Credentialing and Clinical Privileges Committee**

#### **4.1 Statement of Intent**

The Hospital Board will establish a Credentialing and Clinical Privileges Committee for the purpose of assisting the Hospital Board in ensuring that Patients admitted to the Hospital receive the best possible care. This will be achieved through evaluating, monitoring and reviewing the applications made by Medical Practitioners and Allied Health Professionals and making recommendations to the Hospital Board on granting Clinical Privileges to Medical Practitioners and Allied Health Professionals with appropriate Credentials and Competence, subject to Organisational Capability and Organisational Need, in order to maintain the highest possible standards of treatment and care for Patients.

#### **4.2 Role of the Credentialing and Clinical Privileges Committee**

- (1) The Credentialing and Clinical Privileges Committee will be responsible for ensuring that all reasonable professional requirements of Visiting Medical Officers and Visiting Allied Health Professionals are met.
- (2) The Credentialing and Clinical Privileges Committee will advise and make recommendations to the Hospital Board concerning clinical practice, services and other matters which might effect the ability of Visiting Medical Officers and Visiting Allied Health Professionals to deliver the highest possible quality treatment and care to Patients.
- (3) The Credentialing and Clinical Privileges Committee will monitor, review and evaluate the Credentials and Competence of all Medical Practitioners and Allied Health Professionals who make application to become Visiting Medical Officers and Visiting Allied Health Professionals at the Hospital and make recommendations to the Hospital Board on the appointment of Visiting Medical Officers and Visiting Allied Health Professionals and the Clinical Privileges to be granted.

- 
- (4) The Credentialing and Clinical Privileges Committee will make recommendations to the Hospital Board on the appointment of Visiting Medical Officers and Visiting Allied Health Professionals to committees of the Hospital which require participation from Visiting Medical Officers and/or Visiting Allied Health Professionals.
  - (5) The Credentialing and Clinical Privileges Committee will monitor the professional and ethical conduct of all Visiting Medical Officers and Visiting Allied Health Professionals and, where Visiting Medical Officers or Visiting Allied Health Professionals lack Competence, Current Fitness, or have breached the By-Laws and/or engaged in conduct which is disruptive to the Hospital or which may impact upon the quality of treatment and care delivered to their Patients, make recommendations to the Hospital Board on how to deal with those matters.

#### **4.3 Membership of the Committee**

- (1) The membership of the Credentialing and Clinical Privileges Committee will be comprised of the Medical Director, the Director of Clinical Services and at least 2 Visiting Medical Officers.
- (2) The Chief Executive Officer is entitled to be present at meetings of the Credentialing and Clinical Privileges Committee but will not have a vote in decisions made.
- (3) The Credentialing and Clinical Privileges Committee will be appointed by the Hospital Board annually and upon appointment, will recommend to the Hospital Board a chairman from its ranks who will be responsible for convening the Credentialing and Clinical Privileges Committee.
- (4) No member of the Credentialing and Clinical Privileges Committee will be entitled to serve as chairman for any more than 2 consecutive years.
- (5) In order to discharge its functions properly, the Credentialing and Clinical Privileges Committee may co-opt the services of other Visiting Medical Officers and Visiting Allied Health Professionals for clearly defined purposes and those persons will be deemed to be members of the Credentialing and Clinical Privileges Committee for those purposes.

#### **4.4 Meetings of the Credentialing and Clinical Privileges Committee**

- (1) The Credentialing and Clinical Privileges Committee will meet at least 4 times per year at regular intervals.
- (2) At every meeting of the Credentialing and Clinical Privileges Committee fifty percent of the members plus one will constitute a quorum.
- (3) The meetings of the Credentialing and Clinical Privileges Committee must be minuted and copies of the minutes provided to the Chief Executive Officer and to the Hospital Board for consideration at its meetings.

---

## **PART 3 – VISITING MEDICAL OFFICERS**

### **5. Credentialing and Appointment of Visiting Medical Officers**

#### **5.1 Entitlement to treat Patients at the Hospital**

Medical Practitioners who have received Accreditation pursuant to the By-laws are entitled to make a request for access to Hospital facilities for the treatment and care of their Patients within the limits of the Clinical Privileges attached to such Accreditation and to utilise facilities provided by the Hospital for that purpose, subject to the provisions of the By-laws, Hospital policies, resource limitations, and in accordance with Organisational Need and Organisational Capability.

The decision to grant access to Hospital facilities for the treatment and care of a Medical Practitioner's Patients is on each occasion within the sole discretion of the Hospital Board and the grant of Accreditation contains no conferral of a general expectation of or 'right of access'.

#### **5.2 Eligibility for Appointment as a Visiting Medical Officer**

Accreditation as Medical Practitioners will only be granted if Medical Practitioners demonstrate adequate Credentials, are professionally Competent, satisfy the requirements of the By-laws, and are prepared to comply with the By-laws, Hospital policies, relevant legislation, standards and guidelines, including of the relevant medical college, and provide written acknowledgment of such preparedness.

#### **5.3 Applications for Appointment as a Visiting Medical Officer**

Applications for Appointment as Visiting Medical Officers must be made in writing in the prescribed form and must include the following information:

- (1) the applicant's full name, date of birth, professional and private addresses, telephone numbers, facsimile numbers and email addresses;
- (2) the applicant's medical qualifications, including where and when they were obtained;
- (3) details of the applicant's registration with their relevant registration board and current registration number;
- (4) details of any investigation, inquiry or disciplinary action by a registration board or medical college into the applicant's practice and outcome of such investigation or inquiry.
- (5) details of post graduate formal instruction and/or supervised training undertaken by the applicant;
- (6) details of memberships, including of any medical colleges;
- (7) the applicant's past experience, including details of service at other institutions and past (and current) clinical appointments;

- 
- (8) the applicant's current professional indemnity insurance and professional indemnity claims history;
  - (9) any condition, physical or otherwise, which the applicant has which may impact upon Patient safety or quality of care;
  - (10) the Clinical Privileges sought;
  - (11) three professional references or the names of three professional referees;
  - (12) if the applicant no longer has Clinical Privileges at hospitals, where the applicant formerly held Clinical Privileges, and details of why the applicant no longer has Clinical Privileges at those hospitals; and
  - (13) any other information the applicant considers relevant.

The Hospital Board may in its discretion alter the information required to be included in applications and in a particular case may include additional requirements.

Applications must also be accompanied by a declaration signed by the applicant to the effect that the information provided by the applicant is true and correct, and that the applicant will comply in every respect with and accepts the requirements of the By-laws, Hospital policies, relevant legislation, standards and guidelines, including of the relevant medical college in the event that the applicant's application for appointment as a Visiting Medical Officer is approved.

#### **5.4 Responsibility and Basis for Granting Clinical Privileges**

- (1) The Hospital Board will determine applications for Appointment as Visiting Medical Officers and the Clinical Privileges to be granted. In making any determination, the Hospital Board will make independent and informed decisions and in so doing will have regard to the matters set out in the By-Laws and to the observations of the Medical Director and the recommendations of the Credentialing and Clinical Privileges Committee.
- (2) An Appointment as a Visiting Medical Officer is in the complete discretion of the Hospital Board.

### **6. The Process for Appointing and Re-appointing Visiting Medical Officers**

#### **6.1 Applications for Initial Appointment to the Medical Director**

- (1) Applications for initial Appointment as Visiting Medical Officers (where the Medical Practitioner does not already hold Clinical Privileges at the Hospital) are to be submitted to the Medical Director.
- (2) The application must be fully completed and all required information and documents supplied before an application will be considered.

- 
- (3) Applications for initial Appointment should be forwarded to the Medical Director at least two weeks prior to the applicant seeking to commence at the Hospital.
  - (4) The Medical Director may interview applicants and/or request further information or documents from applicants and/or request applicants consent to the Medical Director contacting a third party to obtain information or documents.
  - (5) The Medical Director 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 interviews conducted by the Medical Director and the Medical Director's observations, to the Credentialing and Clinical Privileges Committee.

## **6.2 Consideration by the Credentialing and Clinical Privileges Committee**

- (1) The Credentialing and Clinical Privileges Committee will consider all applications for Appointment as Visiting Medical Officers referred to it by the Medical Director and will make recommendations to the Hospital Board as to whether the applications should be approved and if so, the Clinical Privileges to be granted.
- (2) In considering what recommendation should be made to the Hospital Board, the Credentialing and Clinical Privileges Committee will take into account (but is not limited to consideration of these factors):
  - (a) the information contained in the application;
  - (b) the applicant's Credentials;
  - (c) the applicant's Competence;
  - (d) the applicant's Current Fitness; and
  - (e) any other information provided by the Medical Director.
- (3) If, having considered an application for appointment as a Visiting Medical Officer, the Credentialing and Clinical Privileges Committee concludes that in the absence of further information it is unable to make a decision or based upon current information it would be inclined to recommend to the Hospital Board that the application be declined, it will prepare a detailed statement of the reasons and the evidence relied upon to reach that conclusion ("the Statement").
- (4) The Statement will be forwarded to the applicant within fourteen days (or such longer time period as permitted by the Hospital Board) of the meeting of the Credentialing and Clinical Privileges Committee at which the decision is made under cover of a letter containing the following information:

- 
- (a) details of the insufficiency of information or the proposed recommendation of the Credentialing and Clinical Privileges Committee based upon the current material;
  - (b) a statement to the effect that the Statement has been forwarded to the applicant to enable the applicant to correct, contradict and respond to the issues raised in the Statement both in writing and at a meeting of the Credentialing and Clinical Privileges Committee, or delegates appointed by the Credentialing and Clinical Privileges Committee, if requested by the applicant;
  - (c) a statement to the effect that the applicant must deliver to the Chairman of the Credentialing and Clinical Privileges Committee within 14 days of receipt of the letter from the Credentialing and Clinical Privileges Committee a letter containing:
    - (i) details of the further information required and/or reasons why the applicant disagrees with the issues raised by the Credentialing and Clinical Privileges Committee in the Statement;
    - (ii) any other information the applicant considers relevant to the issues raised in the Statement; and
    - (iii) if the applicant wishes to do so, a request for a meeting with the Credentialing and Clinical Privileges Committee or delegates of the Credentialing and Clinical Privileges Committee to enable the applicant to address the issues raised in the Statement in person. Legal representation is not allowed at this meeting.
- (5) Following receipt of the applicant's letter and, if requested by the applicant, a meeting with the applicant, the Credentialing and Clinical Privileges Committee will make a written recommendation to the Hospital Board to either grant or decline the applicant's application for appointment as a Visiting Medical Officer. In the case of a recommendation to grant the application for appointment as a Visiting Medical Officer, the recommendation will also include details of the Clinical Privileges which the Credentialing and Clinical Privileges Committee recommends be granted and any conditions or limitations recommended. A statement of the Credentialing and Clinical Privileges Committee's reasons for making the recommendation will accompany the recommendation.
- (6) In the event that the Credentialing and Clinical Privileges Committee forms the view that the applicant does not possess the Credentials required for the Clinical Privileges applied for, or is otherwise lacking in Competence, the Credentialing and Clinical Privileges Committee must recommend that the application be declined.
- (7) All proceedings before the Credentialing and Clinical Privileges Committee under this By-Law will be conducted informally and the rules of evidence will have no application.
-

---

### 6.3 Consideration of Applications for Appointment as Visiting Medical Officers by the Hospital Board

- (1) The Hospital Board will consider all applications for Appointment as Visiting Medical Officers referred to it by the Credentialing and Clinical Privileges Committee and will decide whether the applications should be rejected or approved and if approved, the Clinical Privileges to be granted.
- (2) In considering whether to refuse or approve applications and the Clinical Privileges to be granted, the Hospital Board will make an independent and informed decision, having regard to (but not limited to):
  - (a) the information contained in the applicant's application;
  - (b) the matters set out in the By-Laws;
  - (c) the recommendation received from the Credentialing and Clinical Privileges Committee;
  - (d) the observations (if any) of the Chief Executive Officer; and
  - (e) the observations (if any) of the Medical Director.
- (3) The Hospital Board may adjourn the consideration of an application in order to obtain further information from the Credentialing and Clinical Privileges Committee, the applicant or third parties.
- (4) In the event that the Hospital Board requires further information or documents from the applicant or a third party, it will forward a letter to the applicant:
  - (a) informing the applicant that the Hospital Board requires further information or documents from the applicant or third party before deciding whether to approve or refuse the application;
  - (b) identifying the information or documents required; and
  - (c) requesting that the applicant provide the information in writing or submit the documents, or consent to the Hospital Board accessing information or documents from a third party, together with any further information the applicant considers relevant, within 14 days from the date of receipt of the letter.
- (5) In the event that the information or documents requested are not supplied in the time set out in the letter the Hospital Board may, in its discretion, proceed to consider the application without such information.
- (6) The Chairman of the Hospital Board will within fourteen days of the decision of the Hospital Board being finalised forward a letter to the applicant advising the applicant whether the application has been approved or rejected. If the application has been approved, the letter will also contain details of the Clinical Privileges granted, including any terms and conditions. If the application has been rejected, the letter will include a statement of the reasons

---

for rejecting the application and set out the applicant's rights of appeal pursuant to the By-Laws (if available). For a rejection of an application where no appeal is available, there is no requirement to provide a statement of reasons.

- (7) Upon an application being approved, whether by the Hospital Board or following an appeal pursuant the By-Laws, the applicant's name will be entered in the Medical Register.
- (8) There is no right of appeal from a decision to reject an initial application for Accreditation where the applicant does not currently hold Accreditation at the Hospital.

#### **6.4 Reappointment**

- (1) The Medical Director will, at least 3 months prior to the expiration of any term of appointment of each Visiting Medical Officer, provide to that Visiting Medical Officer an application form to be used in applying for reappointment (also referred to as Re-Accreditation).
- (2) Any Visiting Medical Officer wishing to be reappointed must send the completed application form, along with required documents, to the Medical Director at least 2 months prior to the expiration date of the Visiting Medical Officer's current term of Appointment.
- (3) The application form completed by the Visiting Medical Officer must contain sufficient information to enable the Hospital Board to consider the Visiting Medical Officer's application for reappointment.
- (4) The Medical Director, Credentialing and Clinical Privileges Committee, and Hospital Board will deal with applications for reappointment in the same manner in which they are required to deal with applications for initial Appointments as Visiting Medical Officers pursuant to the By-Laws.
- (5) The rights of appeal conferred upon practitioners who apply for re-appointment as Visiting Medical Officers, either following expiry of an initial Appointment or expiry of subsequent Appointments, are set out in By-Law 10

#### **6.5 Tenure**

- (1) Initial Appointments as Visiting Medical Officers will be for a period of 1 year.
- (2) Subsequent Appointments will be for a period of 3 years.
- (3) Appointment as a Visiting Medical Officer does not constitute an employment contract nor does it establish a contractual relationship between the Visiting Medical Officer and the Hospital.
- (4) Accreditation is personal and cannot be transferred to, or exercised by, any other person.

---

## 6.6 Extraordinary Accreditation

### (1) Temporary Accreditation

- (a) The Medical Director may grant Medical Practitioners temporary Accreditation and Clinical Privileges for up to, but no longer than, three months duration on terms and conditions considered appropriate by the Medical Director.
- (b) Temporary Accreditation may be granted on the basis of Patient need, Organisational Capability and Organisational Need.
- (c) Applications for temporary Accreditation must be in the prescribed form and contain all of the information and documents as required for an initial Appointment, otherwise the application will be returned.
- (d) Any Medical Practitioner who has been granted temporary Accreditation must act at all times under the supervision of the Medical Director.
- (e) Temporary Accreditation may be terminated by the Medical Director with the concurrence of the Chairman of the Hospital Board, upon the Medical Director receiving notice of any failure by the Medical Practitioner to comply with the By-Laws or any conditions of the temporary Accreditation.
- (f) In the event that temporary Accreditation is terminated in accordance with the By-Laws, the Medical Practitioner will be required to reassign Patients admitted by the Medical Practitioner to the Hospital for treatment and care to other Visiting Medical Officers.
- (g) Temporary Accreditation will automatically cease upon a determination by the Hospital Board of the Medical Practitioner's application for appointment as a Visiting Medical Officer or at such other time as the Hospital Board decides.
- (h) The Chief Executive Officer and Credentialing and Clinical Privileges Committee will be informed of all temporary Accreditation.
- (i) There is no right of appeal from decisions relating to the granting of temporary Accreditation or termination of temporary Accreditation.

### (2) Emergency Privileges

- (a) In the case of an emergency any Medical Practitioner, to the extent permitted by the terms of the Medical Practitioner's registration, is permitted to assist and to do everything possible for the life of a Patient of that Medical Practitioner or any other Medical Practitioner, using every facility available at the Hospital and calling for any specialist consultations which may be required in order to continue the provision of treatment and care for the Patient.

- 
- (b) For the purposes of this section, “emergency” means a condition which requires treatment to be carried out urgently to meet imminent risks to the person's life or health or to prevent significant pain or distress to the person.
  - (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 Medical Director for the safety of the Patient involved, and will automatically terminate at the expiry of that period or as otherwise determined by the Medical Director.
  - (e) The Chief Executive Officer and Credentialing and Clinical Privileges Committee will be informed of all emergency Accreditation.
  - (f) There will be no right of appeal from decisions granting, or termination of, emergency Accreditation.

## **6.7 Locum Tenens**

- (1) The approval of the Medical Director is required before locums, not Accredited to the Hospital, are permitted to arrange the admission of, and/or to treat Patients, on behalf of Visiting Medical Officers.
- (2) The Medical Director must receive notification in writing of all proposed locum arrangements before such arrangements commence and will as soon as practicable after receipt of such notification, inform the relevant Visiting Medical Officer whether approval is granted to enable the locum to admit and attend Patients at the Hospital.
- (3) Temporary accreditation requirements must be met by the locum before approval of a locum is granted.
- (4) The Medical Director will inform the Chief Executive Officer and Credentialing and Clinical Privileges Committee of all applications for approval of locums and the outcome of those applications.
- (5) There is no right of appeal from decisions in relation to locum appointments.

## **7. Variation of Accreditation or Clinical Privileges**

### **7.1 Application for Variation**

- (1) A Visiting Medical Officer may apply for an amendment or variation of their existing Clinical Privileges 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.
- (2) The process for amendment or variation is the same for an application for Re-Accreditation, and in addition the Visiting Medical Officer is required to provide

---

relevant documentation and references in support of the amendment or variation.

- (3) The rights of appeal conferred upon Visiting Medical Officers who apply for amendment or variation are set out in By-Law 10, except an appeal is not available for an application made in relation to temporary Accreditation, emergency Accreditation, or a locum tenens.

## **8. Review of Accreditation or Clinical Privileges**

### **8.1 Initiation of Review**

- (1) The Hospital Board or Chief Executive Officer may at any time initiate a review of the Visiting Medical Officer's Accreditation or Clinical Privileges where concerns or an allegation are raised about any of the following:
- (a) Patient health or safety could potentially be compromised;
  - (b) the rights or interests of a Patient, staff or someone engaged in or at the Hospital has been adversely affected or could be infringed upon;
  - (c) the Visiting Medical Officer's Competence;
  - (d) the Visiting Medical Officer's Performance;
  - (e) the Visiting Medical Officer's Current Fitness
  - (f) compatibility with Organisational Capability and Organisational Need;
  - (g) confidence in the Visiting Medical Officer;
  - (h) compliance with these By-laws, including terms and conditions, or a possible ground for suspension or termination of Accreditation may have occurred;
  - (i) the efficient operation of the Hospital could be threatened or disrupted, the potential loss of the Hospital's licence or accreditation, or the potential to bring the Hospital into disrepute; or
  - (j) as elsewhere defined in these By-laws.
- (2) The Hospital Board or Chief Executive Officer will determine whether the process to be followed is an:
- (a) Internal review; or
  - (b) External review.
- (3) Prior to determining whether an internal review or external review will be conducted, the Hospital Board or Chief Executive Officer may in their absolute discretion arrange for a representative of the Hospital Board or Chief Executive Officer to meet with the Visiting Medical Officer, along with any

---

other persons the Hospital Board or Chief Executive Officer considers appropriate, advise of the concern or allegation raised, and invite a preliminary response from the Visiting Medical Officer (in writing or orally as determined by the Hospital Board or Chief Executive Officer) before the Hospital Board or Chief Executive Officer makes a determination whether a review will proceed, and if so, the type of review.

- (4) The review may have wider terms of reference than a review of the Visiting Medical Officer's Accreditation or Clinical Privileges.
- (5) The Hospital Board must make a determination whether to impose an interim suspension or conditions upon the Accreditation of the Visiting Medical Officer pending the outcome of the review in accordance with By-Law 9.1.
- (6) In addition or as an alternative to conducting an internal or external review, the Hospital Board will notify the Visiting Medical Officer's registration board and/or other professional body responsible for the Visiting Medical Officer of details of the concerns raised if required by legislation, the Hospital 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 Hospital Board may elect to take action, or further action, under these By-Laws.

## 8.2 Internal Review

- (1) The Hospital Board or Chief Executive Officer will establish the terms of reference of the Internal Review, and may seek assistance of the Medical Director, Credentialing and Clinical Privileges Committee, or co-opted Medical Practitioners or personnel from within the Hospital who bring specific expertise to the Internal Review as determined by the Hospital Board or Chief Executive Officer.
- (2) The terms of reference, process, and reviewers will be as determined by the Hospital Board or Chief Executive Officer. The process will ordinarily include the opportunity for submissions from the Visiting Medical Officer, which may be written and/or oral.
- (3) The Hospital Board or Chief Executive Officer will notify the Visiting Medical Officer in writing of the review, the terms of reference, process and reviewers.
- (4) A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewers to the Hospital Board and Chief Executive Officer.
- (5) Following consideration of the report, the Hospital Board is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate a Visiting Medical Officer's Accreditation in accordance with By-Law 9.

- 
- (6) The Hospital Board must notify the Visiting Medical Officer 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.
  - (7) The Visiting Medical Officer shall have the rights of appeal established by By-Laws 10 in relation to the final determination made by the Hospital Board if a decision is made to amend, suspend, terminate or impose conditions on the Visiting Medical Officer's Accreditation.
  - (8) In addition or as an alternative to taking action in relation to the Accreditation follow receipt of the report, the Hospital Board will notify the Visiting Medical Officer's registration board and/or other professional body responsible for the Visiting Medical Officer of details of the concerns raised and outcome of the review if required by legislation, the Hospital 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 Hospital.

### **8.3 External Review**

- (1) The Hospital Board or Chief Executive will make a determination about whether an External Review will be undertaken
- (2) An External Review will be undertaken by a person(s) external to the Hospital and of the Visiting Medical Officer in question and such person(s) will be nominated by the Hospital Board or Chief Executive Officer at their discretion
- (3) The terms of reference, process, and reviewers will be as determined by the Hospital Board or Chief Executive Officer. The process will ordinarily include the opportunity for submissions from the Visiting Medical Officer, which may be written and/or oral.
- (4) The Hospital Board or Chief Executive Officer will notify the Visiting Medical Officer in writing of the review, the terms of reference, process and reviewers.
- (5) The external reviewer is required to provide a detailed report on the findings of the review in accordance with the terms of reference to the Hospital Board and Chief Executive Officer.
- (6) The Hospital Board will review the report from the External Review and make a determination of whether to continue (including with conditions), amend, suspend or terminate the Visiting Medical Officer's Accreditation or Clinical Privileges in accordance with By-Law 9.
- (7) The Hospital Board must notify the Visiting Medical Officer 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.

- 
- (8) The Visiting Medical Officer shall have the rights of appeal established by By-Law 10 in relation to the final determination made by the Hospital Board if a decision is made to amend, suspend, terminate or impose conditions on the Visiting Medical Officer's Accreditation.
  - (9) In addition or as an alternative to taking action in relation to the Accreditation follow receipt of the report, the Hospital Board will notify the Visiting Medical Officer's registration board and/or other professional body responsible for the Visiting Medical Officer of details of the concerns raised and outcome of the review if required by legislation, the Hospital 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 Hospital.

## **9. Suspension, Termination, Imposition of Conditions, Resignation and Expiry of Accreditation**

### **9.1 Suspension**

- (1) The Hospital Board or Chief Executive Officer may, following consultation with the Chairperson of the Credentialing and Clinical Privileges Committee where appropriate and practicable, immediately suspend a Visiting Medical Officer's Accreditation should the Hospital Board or Chief Executive Officer believe, or have a sufficient concern:
  - (a) It is in the interests of Patient care or safety. This can be based upon an investigation by an external agency including a registration board, disciplinary body, Coroner or the Health Quality & Complaints Commission, and may be related to a patient or patients at another facility not operated by the Hospital;
  - (b) the continuance of the current Clinical Privileges raises a significant concern about the safety and quality of health care to be provided by the Visiting Medical Officer;
  - (c) it is in the interests of staff welfare or safety;
  - (d) serious and unresolved allegations have been made in relation to the Visiting Medical Officer. This may be related to a patient or patients of another facility not operated by the Hospital, including if these are the subject of review by an external agency including a registration board, disciplinary body, Coroner or the Health Quality & Complaints Commission;
  - (e) the Visiting Medical Officer fails to observe the terms and conditions of his/her Accreditation;
  - (f) the behaviour or conduct is in breach of a direction or an undertaking, or the Hospital By-Laws, policies and procedures;

- 
- (g) the behaviour or conduct is such that it is unduly hindering the efficient operation of the Hospital at any time, or is bringing the Hospital into disrepute;
  - (h) the behaviour or conduct of the Visiting Medical Officer is inconsistent with the values of the Hospital;
  - (i) the Visiting Medical Officer has been suspended by his/her registration board;
  - (j) 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 Visiting Medical Officer;
  - (k) the Visiting Medical Officer's professional registration is amended, or conditions imposed, or undertakings agreed, irrespective of whether this relates to a current or former Patient of the Hospital;
  - (l) the Visiting Medical Officer has made a false declaration or provided false or inaccurate information to the Hospital, either through omission of important information or inclusion of false or inaccurate information;
  - (m) the Visiting Medical Officer 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;
  - (n) the Accreditation or Clinical Privileges of the Visiting Medical Officer has been suspended, terminated, restricted or made conditional by another health care organisation;
  - (o) the Visiting Medical Officer is the subject of a criminal investigation about a serious matter (for example a drug related matter, or an allegation of a crime against a person such as a sex or violence offence) which, if established, could affect his or her ability to exercise his or her Clinical Privileges safely and competently and with the confidence of the Hospital and the broader community;
  - (p) the Visiting Medical Officer has been convicted of a crime which could affect his or her ability to exercise his or her Clinical Privileges safely and competently and with the confidence of the Hospital and the broader community;
  - (q) 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;
  - (r) an internal review or external review has been initiated pursuant to these By-Laws and the Hospital Board or Chief Executive Officer

---

considers that an interim suspension is appropriate pending the outcome of the review; or

- (s) there are other unresolved issues or other concerns in respect of the Visiting Medical Officer that is considered to be a ground for suspension.
- (2) The Hospital Board or Chief Executive Officer shall notify the Visiting Medical Officer of:
- (a) the fact of the suspension;
  - (b) the period of suspension;
  - (c) the reasons for the suspension;
  - (d) if the Hospital Board or Chief Executive considers it applicable and appropriate in the circumstances, invite a written response from the Visiting Medical Officer, including a response why the Visiting Medical Officer may consider the suspension should be lifted;
  - (e) if the Hospital Board or Chief Executive Officer 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
  - (f) the right of appeal, the appeal process and the time frame for an appeal.
- (3) As an alternative to an immediate suspension, the Hospital Board or Chief Executive Officer may elect to deliver a show cause notice to the Visiting Medical Officer advising of:
- (a) the facts and circumstances forming the basis for possible suspension;
  - (b) the grounds under the By-Laws upon which suspension may occur;
  - (c) invite a written response from the Visiting Medical Officer, including a response why the Visiting Medical Officer may consider suspension is not appropriate;
  - (d) if applicable and appropriate in the circumstances, any actions that must be performed for the suspension not to occur and the period within which those actions must be completed; and
  - (e) a timeframe in which a response is required from the Visiting Medical Officer to the show cause notice;

Following receipt of the response the Hospital Board or Chief Executive Officer will determine whether the Accreditation will be suspended. If suspension is to occur, notification will be sent in accordance with paragraph (2). Otherwise the Visiting Medical Officer will be advised that suspension will

---

not occur, however this will not prevent the Hospital Board or Chief Executive Officer from taking other action at this time, including imposition of conditions, and will not prevent the Hospital Board or Chief Executive Officer from relying upon these matters as a ground for suspension or termination in the future.

- (4) The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by the Hospital Board or Chief Executive Officer.
- (5) The affected Visiting Medical Officer shall have the rights of appeal established by By-Law 10.
- (6) 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 Visiting Medical Officer including but not limited to patients outside of the Hospital, it is in the interests of Patient care or safety to do so, it is in the 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 Hospital Board or Chief Executive Officer will notify the Visiting Medical Officer's registration board and/or other relevant regulatory agency of the suspension and the reasons for it.

## 9.2 Termination

- (1) Accreditation shall be immediately terminated by the Hospital Board or Chief Executive Officer if the following has occurred, or if it appears based upon the information available to the Hospital Board or Chief Executive Officer the following has occurred:
  - (a) the Visiting Medical Officer ceases to be registered with their relevant registration board;
  - (b) the Visiting Medical Officer ceases to maintain Adequate Professional Indemnity Insurance covering the Clinical Privileges; or
  - (c) a contract of employment or to provide services is terminated or ends, and is not renewed.
- (2) Accreditation may be terminated by the Hospital Board or Chief Executive Officer if the following has occurred, or if it appears based upon the information available to the Hospital Board or Chief Executive Officer the following has occurred:
  - (a) based upon any of the matters in By-Law 9.1 and it is considered suspension is an insufficient response in the circumstances;
  - (b) 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 Hospital Board or Chief Executive Officer does not have confidence in the continued appointment of the Visiting Medical Officer;

- 
- (c) the Visiting Medical Officer is not regarded by the Hospital Board or Chief Executive Officer as having the appropriate Current Fitness to retain Accreditation or the Clinical Privileges, or the Hospital Board or Chief Executive Officer does not have confidence in the continued appointment of the Visiting Medical Officer;
  - (d) conditions have been imposed by the Visiting Medical Officer's registration board on clinical practice that restricts practice and the Hospital does not have capacity to meet the results of the conditions imposed;
  - (e) the Visiting Medical Officer has not exercised Accreditation or utilised the facilities at the Hospital for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Visiting Medical Officer by the Hospital Board;
  - (f) the Clinical Privileges are no longer supported by Organisational Capability or Organisational Need;
  - (g) the Visiting Medical Officer 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
  - (h) there are other unresolved issues or other concerns in respect of the Visiting Medical Officer that is considered to be a ground for termination.
- (3) The Accreditation of a Visiting Medical Officer may be terminated as otherwise provided in these By-Laws.
- (4) The Hospital Board or Chief Executive Officer shall notify the Visiting Medical Officer of:
- (a) the fact of the termination;
  - (b) the reasons for the termination;
  - (c) if the Hospital Board or Chief Executive Officer considers it applicable and appropriate in the circumstances, invite a written response from the Visiting Medical Officer why he/she may consider a termination should not have occurred; and
  - (d) if a right of appeal is available in the circumstances, the right of appeal, the appeal process and the time frame for an appeal.
- (5) As an alternative to an immediate termination, the Hospital Board or Chief Executive Officer may elect to deliver a show cause notice to the Visiting Medical Officer advising of:
- (a) the fact and circumstances forming the basis for possible termination;
  - (b) the grounds under the By-Laws upon which termination may occur;
-

- 
- (c) invite a written response from the Visiting Medical Officer, including a response why the Visiting Medical Officer may consider termination is not appropriate;
  - (d) if applicable and appropriate in the circumstances, any actions that must be performed for the termination not to occur and the period within which those actions must be completed; and
  - (e) a timeframe in which a response is required from the Visiting Medical Officer to the show cause notice;

Following receipt of the response the Hospital Board or Chief Executive Officer will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with paragraph (4). Otherwise the Visiting Medical Officer will be advised that termination will not occur, however this will not prevent the Hospital or Chief Executive Officer from taking other action at this time, including imposition of conditions, and will not prevent the Hospital Board or Chief Executive Officer from relying upon these matters as a ground for suspension or termination in the future.

- (6) For a termination of Accreditation pursuant to By-Law 9.2(1), there shall be no right of appeal.
- (7) For a termination of Accreditation pursuant to By-Law 9.2(2), the Visiting Medical Officer shall have the rights of appeal established by these By-laws.
- (8) Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by Hospital Board or Chief Executive Officer to the Visiting Medical Officer's registration board and/or other relevant regulatory agency.

### **9.3 Imposition of Conditions**

- (1) At the conclusion of or pending finalisation of an internal or external review pursuant to these By-Laws or in lieu of a suspension or termination of Clinical Privileges, the Hospital Board or Chief Executive Officer may elect to impose conditions on the Accreditation or Clinical Privileges.
- (2) The Hospital Board or Chief Executive Officer must notify the Visiting Medical Officer 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. If the Hospital Board or Chief Executive Officer considers it applicable and appropriate in the circumstances, they may also invite a written response from the Visiting Medical Officer as to why the Visiting Medical Officer may consider the conditions should not be imposed.
- (3) If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Hospital Board or Chief Executive Officer.
- (4) The affected Medical Practitioner shall have the rights of appeal established by these By-Laws.

- 
- (5) 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 Hospital Board or Chief Executive Officer will notify the Visiting Medical Officer's registration board and/or other relevant regulatory agency of the imposition of the conditions and the reasons the conditions were imposed.

#### **9.4 Resignation and Expiry of Accreditation**

- (1) A Visiting Medical Officer may resign his/her Accreditation by giving one month's notice of the intention to do so to the Medical Director of the Hospital, unless a shorter notice period is otherwise agreed by the Medical Director.
- (2) A Visiting Medical Officer who intends ceasing treating Patients either indefinitely or for an extended period must notify his/her intention to the Medical Director, and Accreditation will be taken to be withdrawn one month from the date of notification unless the Medical Director decides a shorter notice period is appropriate in the circumstances.
- (3) If an application for Re-Accreditation is not received within the timeframe provided for in these By-Laws, unless determined otherwise by the Hospital Board, the Accreditation will expire at the conclusion of its term. If the Visiting Medical Officer wishes to admit or treat Patients at the Hospital after the expiration of Accreditation, an application for Accreditation must be made as an application for initial Accreditation.
- (4) If the Visiting Medical Officer's Clinical Privileges are no longer supported by Organisational Capability or Organisational Need, if the Visiting Medical Officer will no longer be able to meet the terms and conditions of Accreditation, or where admission of Patients or utilisation of services at the Hospital is regarded by the Hospital Board to be insufficient, the Hospital Board or Chief Executive Officer will raise these matters in writing with the Visiting Medical Officer and invite a meeting to discuss, following which the Hospital Board / Chief Executive Officer and Visiting Medical Officer may agree that Accreditation will expire and they will agree on the date for expiration of Accreditation. Following the date of expiration, if the Visiting Medical Officer wishes to admit or treat Patients at the Hospital, an application for Accreditation must be made as an application for initial Accreditation.
- (5) The provisions in relation to resignation and expiration of Accreditation in no way limit the ability of the Hospital Board or Chief Executive Officer to take action pursuant to other provisions of these By-Laws, including by way of suspension or termination of Accreditation.

### **10. Appeals**

#### **10.1 Rights of Appeal**

- (1) There shall be no right of appeal against a decision to not approve initial, temporary, emergency or locum Accreditation, or continued Accreditation at the end of a temporary, emergency or locum Accreditation period.

- 
- (2) Subject to paragraph (1) above, a Visiting Medical Officer shall have the rights of appeal as set out in these By-Laws.

## 10.2 Appeal Process

- (1) A Visiting Medical Officer 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.
  - (2) An appeal must be in writing to the Chairperson of the Hospital Board and received by the Chairperson of the Hospital Board within the fourteen (14) day appeal period or else the right to appeal is lost.
  - (3) Unless decided otherwise by the Hospital 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.
  - (4) Upon receipt of an appeal notice the Chairperson of the Hospital Board will nominate an Appeal Committee to hear the appeal, will establish terms of reference, and will submit all relevant material to the chairperson of the Appeal Committee.
  - (5) The Appeal Committee shall comprise at least three (3) persons and will include:
    - (a) a nominee of the Hospital Board who will ordinarily (but not necessarily) be a senior healthcare professional external to the Hospital, who must be independent of the decision under appeal regarding the Visiting Medical Officer, and who will be the chairperson of the Appeal Committee;
    - (b) a nominee of the Chief Executive Officer who will ordinarily (but not necessarily) be a member of the same medical college or association as the Visiting Medical Officer, who may be an Accredited Practitioner, and who must be independent of the decision under appeal regarding the Visiting Medical Officer;
    - (c) any other member or members who bring specific expertise to the decision under appeal, as determined by the Hospital Board, who must be independent of the decision under appeal regarding the Visiting Medical Officer, and who may be an Accredited Practitioner. The Hospital Board may in their complete discretion invite the appellant to make suggestions or comments on the proposed additional members of the Appeal Committee (other than the nominees in (a) and (b) above), but is not bound to follow the suggestions or comments.
  - (6) 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 Hospital Board will notify the appellant of the members of the Appeal Committee.
-

- 
- (7) 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, 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.
  - (8) The appellant will be given the opportunity to make a submission to the Appeal Committee. The Appeal Committee shall determine whether the submission by the appellant may be in writing or in person or both.
  - (9) 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.
  - (10) The Chief Executive Officer (or nominee) may present to the Appeals Committee in order to support the decision under appeal.
  - (11) 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.
  - (12) The appellant shall not be present during Appeal Committee deliberations except when invited to be heard in respect of his/her appeal.
  - (13) The chairperson of the Appeal Committee shall determine any question of procedure for the Appeal Committee, with questions of procedure entirely within the discretion of the chairperson of the Appeal Committee.
  - (14) The Appeal Committee will make a written recommendation regarding the appeal to the Hospital 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 appellant.
  - (15) The Hospital Board will consider the recommendation of the Appeal Committee and make a decision about the appeal.
  - (16) The decision of the Hospital Board will be notified in writing to the appellant.
  - (17) The decision of the Hospital Board is final and binding, and there is no further appeal allowed under these By-Laws from this decision.

- 
- (18) If a notification has already been given to an external agency, such as a registration board, then the Hospital Board will notify that external agency of the appeal decision. If a notification has not already been given, the Hospital 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 4 – VISITING ALLIED HEALTH PROFESSIONALS**

### **11. Accreditation of Visiting Allied Health Professionals**

The Provisions of Part 3 of these By-Laws are hereby repeated in full, substituting where applicable Visiting Allied Health Professional and Allied Health Privileges.

Applications for initial Accreditation and Re-Accreditation should be submitted on the appropriate form for Allied Health Professionals.

Following Accreditation the Visiting Allied Health Professional will be entered on the Allied Health Professionals Register.

## **PART 5 – GENERAL TERMS AND CONDITIONS FOR ACCREDITED PRACTITIONERS**

### **12. Ethics and Expectations**

#### **12.1 Compliance with By-Laws**

- (1) It is a requirement for continued Accreditation that Accredited Practitioners comply with the By-laws at all relevant times.
- (2) Any incidence of non-compliance with the By-laws may be grounds for suspension, termination, imposition of conditions, or other action as permitted by the By-laws.

#### **12.2 Hospital Policies and Procedures**

- (1) Accredited Practitioners must comply with all policies and procedures (including amendments) adopted by the Hospital Board from time to time.

#### **12.3 Standard of Conduct**

- (1) The Hospital Board expects a high standard of professional and personal conduct from Accredited Practitioners, who must conduct themselves at all times in accordance with:
  - (a) the By-Laws;
  - (b) the limits of their registration;

- 
- (c) any conditions or delineation imposed upon their Clinical Privileges;
  - (d) all reasonable requests made by representatives of the Hospital with regard to personal conduct in the Hospital;
  - (e) all relevant legislation, including legislation that relates to health and aged care, workplace health and safety, occupational health and safety, antidiscrimination, bullying, harassment, care of children, care of the aged, professional health registration, and any other relevant legislation regulating the Accredited Practitioner and provision of health care in Queensland;
  - (f) the Code of Ethics of the Australian Medical Association or any other relevant code of ethics; and
  - (g) the Code of Practice of any specialist college or professional body of which the Accredited Practitioner is a member.
- (2) Accredited Practitioners must continuously demonstrate Competence and Current Fitness.
  - (3) Upon request by the Hospital Board, Chief Executive Officer or Medical Director, the Accredited Practitioner is required to meet with either or any of them to discuss matters in (1) or (2) above, or any other matter arising out of the By-Laws.

#### **12.4 Insurance and Registration**

- (1) Accredited Practitioners must at all times maintain Adequate Professional Indemnity Insurance and registration with their relevant health registration board in Queensland.
- (2) Accredited Practitioners are required to provide evidence annually, or at other times upon request, of Adequate Professional Indemnity Insurance and registration with the relevant professional registration board in Queensland, and all other relevant licences or registration requirements for the Clinical Privileges granted.

#### **12.5 Notifications**

- (1) Accredited Practitioners must immediately advise the Chief Executive Officer or Medical Director, and follow up with written confirmation within 2 days, should:
  - (a) an investigation be commenced in relation to the Accredited Practitioner, or about his/her Patient (irrespective of whether this relates to a Patient of the Hospital) by the Accredited Practitioner's registration board, disciplinary body, Coroner, Health Quality & Complaints Commission, or another statutory authority;
  - (b) an adverse finding be made against the Accredited Practitioner by a civil court, the practitioner's registration board, disciplinary body,

---

Coroner, Health Quality & Complaints Commission, or another statutory authority, irrespective of whether this relates to a Patient of the Hospital;

- (c) the Accredited Practitioner's professional registration be revoked or amended, or should conditions be imposed, or should undertakings be agreed, irrespective of whether this relates to a Patient of the Hospital and irrespective of whether this is noted on the public register or is privately agreed with a registration board;
- (d) professional indemnity membership or insurance be made conditional or not be 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 withdrawn, suspended, restricted, or made conditional; or
- (f) the Accredited Practitioner be charged with having committed or is convicted of a sex, violence or other criminal offence. The Accredited Practitioner must provide the Hospital with an authority to conduct at any time a criminal history check with the appropriate authorities.

## 12.6 Continuous Disclosure

- (1) The Accredited Practitioner must keep the Chief Executive Officer or Medical Director continuously informed of every fact and circumstance which has, or will likely have, a material bearing upon:
  - (a) the Accreditation of the Accredited Practitioner;
  - (b) the Clinical Privileges of the Accredited Practitioner;
  - (c) the ability of the Accredited Practitioner to safely deliver health services to his/her Patients within the Clinical Privileges granted;
  - (d) the Accredited Practitioner's registration or professional indemnity insurance arrangements;
  - (e) the inability of the Accredited Practitioner to satisfy a medical malpractice claim by a Patient;
  - (f) adverse outcomes or complications in relation to the Accredited Practitioner's Patients (current or former) of the Hospital;
  - (g) the reputation of the Accredited Practitioner as it relates to the provision of clinical services; and
  - (h) the reputation of the Hospital.

- 
- (2) Subject to restrictions directly relating to or impacting upon legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the Chief Executive Officer or Medical Director informed and updated about the commencement, progress and outcome of compensation claims (including a *Personal Injuries Proceedings Act* initial notice or notice of claim), coronial investigations or inquests, police investigations, complaints body (including the Health Quality & Complaints Commission) complaints or investigations, or other inquires involving Patients of the Accredited Practitioner that were treated at the Hospital.

## 12.7 Representation and Media

- (1) Unless an Accredited Practitioner has the prior written consent of the Hospital Board or Chief Executive Officer, an Accredited Practitioner may not use the Hospital name or Hospital letterhead or in any way suggest that the Accredited Practitioner represents the Hospital.
- (2) The Accredited Practitioner must obtain the Hospital Board's or Chief Executive Officer's prior approval before interaction with the media regarding any matter involving the Hospital or a Patient.

## 12.8 Committees

- (1) The Hospital Board requires Accredited Practitioners, as reasonably requested by the Chief Executive Officer or Medical Director, to assist it in achieving its objectives through membership of committees of the Hospital and assisting in the provision of education and teaching. This includes committees responsible for developing, implementing and reviewing policies in all clinical areas; clinical speciality committees; quality assurance committees; participating in medical, nursing and other education programs; and attending meetings of Accredited Practitioners.

## 12.9 Confidentiality

- (1) Subject to requirements in the By-Laws, Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with the Hospital policy and the 'National Privacy Principles' established by the *Privacy Act (Cth)* and will not do anything to bring the Hospital in breach of these obligations.
- (2) Subject to requirements in the By-Laws, Accredited Practitioners will comply with the various legislation governing the collection, handling, storage and disclosure of health information.
- (3) Subject to requirements in the By-Laws, Accredited Practitioners will comply with common law duties of confidentiality.
- (4) The above requirements continue with full force and effect after the Accredited Practitioner ceases to be Accredited.

---

## 12.10 Admission, Availability, Communication and Discharge

- (1) Accredited Practitioners who admit Patients to the Hospital for treatment and care 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.
- (2) 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. Absent special circumstances, an Accredited Practitioner will review a Patient within 24 hours of the Patient being admitted under that Accredited Practitioner. An Accredited Practitioner will review the Patient on a daily basis or 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 Hospital. Accredited Practitioners must ensure that all reasonable requests by Hospital staff are responded to in a timely manner and in particular Patients are promptly attended to when reasonably requested by Hospital 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 Hospital of this arrangement.
- (3) Accredited Practitioners must be available and attend upon Patients of the Accredited Practitioner in a timely manner when requested by Hospital staff or be available by telephone in a timely manner to assist Hospital staff in relation to the Accredited Practitioner's Patients. Alternatively, the Accredited Practitioner will make arrangements with another Accredited Practitioner to assist or will put in place with prior notice appropriate arrangements in order for another Accredited Practitioner to assist, and shall advise the staff of the Hospital of this arrangement.
- (4) It is the responsibility of the Accredited Practitioner to ensure any changes to contact details are notified promptly to the Medical Director. 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. Accredited Practitioners must ensure that they have in place on-call and cover arrangements with Accredited Practitioner(s) at the Hospital and that those arrangements are communicated to the Hospital. A locum must be approved in accordance with the requirements of the By-Laws and the Accredited Practitioner must ensure that the locum's contact details are made available to the Hospital and all relevant persons are aware of the locum cover and the dates of locum cover.
- (5) Accredited Practitioners must only treat Patients within the delineation of the Clinical Privileges granted.
- (6) 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 Hospital executive, Patients and the Patient's family or next of kin, and at all times ensure appropriate communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.

- (7) Adequate instructions and clinical handover is required to be given to the Hospital 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. The Accredited Practitioner must appropriately supervise the care that is provided by the Hospital staff and other practitioners.
- (8) If care is transferred to another Accredited Practitioner, this must be noted on the Patient medical record and communicated to the Nurse Unit Manager or other responsible nursing staff member.
- (9) Accredited Practitioners must participate in formal on call arrangements as reasonably required by the Hospital. Persons providing on-call or cover services must be Accredited at the Hospital.
- (10) 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 Hospital. It is the responsibility of the Accredited Practitioner to ensure all information reasonably necessary for continuity of care after discharge is provided to the referring practitioner, general practitioner or other treating practitioner.

#### **12.11 Utilisation**

- (1) Accredited Practitioners will be advised upon Accreditation or Re-Accreditation, or at other times as determined by the Hospital Board or Chief Executive Officer, 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.

#### **12.12 Informed Consent and Financial Consent**

- (1) 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 and in accordance with the policy and procedures of the Hospital. 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.
- (2) The consent will be evidenced in writing and signed by the Accredited Practitioner and Patient or their legal guardian or substituted decision maker.

- 
- (3) It is expected that fully informed consent will be obtained by the Accredited Practitioner under whom the Patient is admitted. 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, and then obtain the consent to treatment. The consent process must also satisfy the Hospital's requirements from time to time as set out in its policy and procedures.
  - (4) 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 Hospital.

### 12.13 Patient Records

- (1) Accredited Practitioners must ensure that:
  - (a) Patient records held by the Hospital are adequately maintained for Patients treated by the Accredited Practitioner;
  - (b) Patient records satisfy Hospital policy requirements, legislative requirements, the content and standard required by the Australian Council on Healthcare Standards, accreditation requirements, health fund obligations and relevant Queensland Health and other bodies requirements;
  - (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;
  - (d) Patient records include all relevant information and documents reasonably necessary to allow Hospital staff and other Accredited Practitioners to care for patients;
  - (e) A procedure report is completed including a detailed account of the findings, technique undertaken, complications and post procedure orders; and
  - (f) An anaesthetic report is completed, as well as documentation evidencing fully informed anaesthetic consent.

### 12.14 Financial Information and Statistics

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

---

## 12.15 Quality Improvement, Risk Management and Regulatory Agencies

- (1) Accredited Practitioners are required to attend and participate in the Hospital's safety, quality, risk management, education and training activities, including clinical audit and peer review activities, and as required by relevant legislation, standards and guidelines, including but not limited to the Health Quality & Complaints Commission Act and its accompanying standards.
- (2) Accredited Practitioners will report to the Hospital incidents and adverse events (including in relation to the Accredited Practitioner's Patients) in accordance with the Hospital policy and procedures and where required by the Chief Executive Officer or Medical Director will assist with incident management, investigation and reviews (including root cause analysis and other systems reviews), and open disclosure processes.
- (3) Accredited Practitioners will participate in risk management activities and programs, including the implementation by the Hospital of risk management strategies and recommendations from system reviews.
- (4) Accredited Practitioners must provide all reasonable and necessary assistance in circumstances where the Hospital requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction, including for example where that direction is pursuant to a court order, or for example from the Health Quality & Complaints Commission, Coroner, Police, State of Queensland and its agencies or departments, Private Health Unit, and Commonwealth Government and its agencies or departments.

## 12.16 Research

- (1) The Hospital approves, in principle, the conduct of research (including a clinical trial) in the Hospital. However, no research will be undertaken without the prior approval of the Hospital Board and the relevant Human Research Ethics Committee, following written application by the Accredited Practitioner.
- (2) The activities to be undertaken in the research must fall within the Clinical Privileges of the Accredited Practitioner.
- (3) For aspects of the research falling outside an 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.
- (4) 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.
- (5) An Accredited Practitioner has no power to bind the Hospital to a research project (including a clinical trial) by executing a research agreement.

- 
- (6) There is no right of appeal from a decision to reject an application for research.

#### 12.17 **New Clinical Services**

- (1) Notwithstanding the Clinical Privileges granted, Accredited Practitioners must not use New Clinical Services on Patients admitted to the Hospital without the approval of the Hospital Board.
- (2) If an Accredited Practitioner wishes to use New Clinical Services in the care and treatment of Patients admitted to the Hospital, the Accredited Practitioner must submit to the Medical Director in writing a request to utilise the New Clinical Services, which contains:
- (a) details of the New Clinical Services;
  - (b) if applicable, details of any approval granted by the Therapeutic Goods Administration;
  - (c) details of any relevant medical or other college or association endorsements;
  - (d) details of literary reviews;
  - (e) details of the Accredited Practitioner's training and experience;
  - (f) confirmation that the Accredited Practitioner's professional indemnity insurance will cover the New Clinical Services; and
  - (g) evidence that private health funds will adequately fund the New Clinical Services.
- ("the Application").
- (3) The Medical Director will refer the Application to the Credentialing and Clinical Privileges Committee together with any relevant comments the Medical Director may have.
- (4) The Credentialing and Clinical Privileges Committee will consider the Application and make recommendations to the Hospital Board relating to:
- (a) the use of the New Clinical Services;
  - (b) the Accredited Practitioner's ability to use or carry out the New Clinical Services, as well as its risks and benefits.
- (5) If research is involved, then approval must also be obtained by the Human Research Ethics Committee before consideration by the Hospital Board.
- (6) The Hospital Board will consider the Application and make an independent and informed decision having regard to:

- 
- (a) the Application;
  - (b) comments by the Medical Director (if any); and
  - (c) the recommendations of the Credentialing and Clinical Privileges Committee.
- (7) The Chairman of the Hospital Board will advise the Accredited Practitioner of the outcome of the Application in writing within 14 days of the date of the meeting which it was considered by the Hospital Board.
- (8) The Hospital Board's decision is final and there shall be no right of appeal from denial of requests for New Clinical Services.

## **PART 6 – AMENDING BY-LAWS**

### **13. Amendments to By-Laws**

Amendments to these By-Laws can only be made by a resolution of the Hospital Board.

All Accredited Practitioners will be bound by amendments to the By-Laws from the date of approval of the amendments by the Hospital Board, even if Accreditation was obtained prior to the amendments being made.

If amendments are to have retrospective application, this must be specifically stated by the Hospital Board.