Medical Practitioner By-laws

EFFECTIVE DATE: 11th April 2019

AUTHORISED:

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A/Group Chief Executive Officer

Contents

PART I – PRELIMINARY

1. DEFINITIONS AND INTERPRETATION

The defined terms and interpretation clauses for these By-laws are contained in Schedule 1.

2. PURPOSE AND EFFECT OF THESE BY-LAWS

Purpose

2.1 The purpose of these By-laws is to promote:

(a) the maintenance of SJGHC Mission, Vision and Values and compliance with the Statement of Principles;

(b) the achievement of SJGHC's business and strategic objectives;

(c) adherence to the requirements of the Australian Commission for Safety and Quality in Health Care, the National Safety and Quality Health Service Standards, the National Standards for Mental Health Services and the QIC Health and Community Services Standards (as applicable), subsequently described as '**mandatory accreditation standards**'.

(d) adherence to accountabilities within the SJGHC Patient Safety and Clinical Exellence Framework; and

(e) continuous improvement in the safety and quality of Health Care Services provided at SJGHC Hospitals/Services —

by setting out:

(f) the arrangements that govern the relationship between SJGHC and its Accredited Medical Practitioners;

(g) procedures and requirements for the Accreditation and Authorised Scope of Practice of Medical Practitioners at SJGHC;

(h) Conduct Rules and other requirements to be observed by Medical Practitioners providing Health Care Services at SJGHC Hospitals/Services; and

(i) requirements for committees and processes to facilitate, monitor and manage the delivery of quality Health Care Services.

Legal effect

2.2 These By-laws do not, of themselves:

(a) create any contractual or employment relationship between SJGHC and any Medical Practitioner; or

(b) confer on any Medical Practitioner any legally enforceable right, or create in any Medical Practitioner any legitimate expectation, in relation to any matter or thing referred to in them.

2.3 However, it is contemplated that these By-laws, or parts of these By-laws, may be given legal effect (including by imposing binding legal obligations upon Medical Practitioners) by being adopted or applied, in whole or in part, in:

(a) contracts, licences and other binding legal arrangements entered into between SJGHC and Accredited Medical Practitioners; and

(b) employment contracts or Contracts for Services entered into between SJGHC and Employed or Contracted Medical Practitioners.

Authority to make and amend By-laws

2.4 The Group CEO may from time to time amend, suspend or revoke these By-Laws or any part of these By-laws.

2.5 The Group CEO shall use reasonable endeavours to ensure that timely notice of an amendment or the suspension or revocation of the By-laws or part of the By-laws is given to Accredited Medical Practitioners.

3. MISSION, VISION, VALUES AND ETHICAL PRINCIPLES

Medical Practitioners must uphold

3.1 Medical Practitioners who provide Health Care Services at Hospitals/Services of SJGHC are required to respect and comply with the moral teachings of the Catholic Church, and must at all times:

(a) uphold the Mission, Vision and Values set out at Schedule 2; and

(b) comply with the Statement of Principles set out at Schedule 3.

Medical Practitioners must seek guidance when in doubt

3.2 If any doubt or question arises as to whether any practice infringes or is contrary to the teachings, laws and traditions of the Catholic Church, the Medical Practitioner shall refer the matter to the Hospital/Service CEO for guidance.

PART II - ROLES AND RESPONSIBILITIES

4. ROLES AND RESPONSIBILITIES

GROUP MEDICAL SERVICES

4.1 Group Medical Services under the leadership of the Director of Medical Services is responsible for defining governance over Scope of Practice and the credentialing platform.

HOSPITAL/SERVICE CHIEF EXECUTIVE OFFICER

Responsibility

4.2 The Hospital/Service CEO is generally responsible for managing the Hospital/Service and is responsible under these By-laws for:

(a) the Accreditation of Medical Practitioners and Dentists to provide Health Care Services in the Hospital/Service;

(b) defining the Authorised Scope of Practice of Accredited Medical Practitioners and Employed or Contracted Medical Practitioners (other than Supervised Practitioners) aligned to a Scope of Practice Tree as defined by Group Medical Services;

(c) establishment of the committees required by these By-laws and such other committees and sub-committees as may be appropriate from time to time;

(d) completing and submitting to the Group CEO the Australian Commission on Safety and Quality in Health Care annual Attestation Statement relevant to the Hospital/Service; and

(e) providing executive leadership and direction within the Hospital/Service.

Discretion

4.3 Except where it is expressly provided in these By-laws to the contrary:

(a) any decision, determination, direction or action that the Hospital/Service CEO is empowered or required to make, give or take under these By-laws shall be at the absolute discretion of the Hospital/Service CEO; and

(b) the Hospital/Service CEO is not required to give reasons.

Delegation

4.4 The CEO may delegate to any employee or officer of SJGHC any power, function or duty of the CEO under these By-laws (other than the power to make or amend the By-laws).

5. HOSPITAL/SERVICE MANAGEMENT COMMITTEE

Establishment of Hospital/Service Management Committee

5.1 A Hospital/Service Management Committee shall be established in each Hospital/Service to provide advice, support and assistance to the Hospital/Service CEO.

Functions of Hospital/Service Management Committee

5.2 The Hospital/Service Management Committee shall be responsible for assisting and advising the Hospital/Service CEO in relation to:

(a) implementing the operational and strategic plans of the Hospital/Service;

(b) monitoring and evaluating the quality, effectiveness, relevance and utility of health care services provided in the Hospital/Service;

(c) determining the health care needs of the local community and an appropriate role for the Hospital/Service and SJGHC in satisfying those needs;

(d) developing and reviewing policies directed towards ensuring the provision of quality health care services and the proper planning, management and monitoring of the performance of the Hospital/Service in accordance with the SJGHC Mission, Vision and Values and Statement of Principles;

(e) ensuring systems and processes are in place to meet the requirements of the mandatory accreditation statements;

(f) ensuring caregivers meet the obligations of the SJGHC Patient Safety and Clinical Excellence Framework; and

(g) such other matters as are determined by the Hospital/Service CEO.

Membership and procedure

5.3 The Hospital/Service CEO shall, in respect of the Hospital/Service Management Committee, determine:

(a) the membership of the Committee;

(b) the terms of reference of the Committee;

(c) the rules and procedures for deliberations of the Committee, including procedures for recording attendance at meetings and decisions of the Committee; and

(d) such other matters relating to the membership and proceedings of the Committee as the Hospital/Service CEO thinks fit.

6. QUALITY COMMITTEES

Establishment of Quality Committee

6.1 The Hospital/Service CEO must ensure that there is established a committee or group that has responsibility for monitoring and evaluating the quality of Health Care Services provided in each Hospital/Service ('Quality Committee').

6.2 For the purpose of By-law 6.1 the Hospital/Service CEO may:

(a) establish a stand-alone Quality Committee for the Hospital/Service; or

(b) designate the Hospital/Service Management Committee to be a Quality Committee for the Hospital/Service—

provided that as far as practicable the Hospital/Service CEO shall seek to ensure that Medical Practitioners within the Hospital/Service are engaged in effective quality activities.

7. MEDICAL ASSOCIATION

Establishment and role of Medical Association

7.1 A Medical Association shall be established in each Hospital/Service to:

(a) provide a forum for communication between the Hospital/Service and Medical Practitioners; and

(b) perform such other functions as are agreed with the Hospital/Service CEO.

Membership of Medical Association

7.2 The following shall be members of the Medical Association:

(a) all Medical Practitioners (except Supervised Practitioners); and

(b) the Hospital/Service DMS (where appointed).

Chairperson of Medical Association

7.3 The chairperson of the Medical Association shall be elected by the members at the annual general meeting of the Medical Association.

Meetings of Medical Association

7.4 Meetings of the Medical Association shall be held at a time and place, and in accordance with procedures, determined from time to time by the Medical Advisory Committee in consultation with the Hospital/Service CEO.

8. MEDICAL ADVISORY COMMITTEE

Establishment of Medical Advisory Committee

8.1 A Medical Advisory Committee shall be established in each Hospital/Service.

Functions of Medical Advisory Committee

8.2 The Medical Advisory Committee shall promote the delivery of Health Care Services within the Hospital/Service that are:

(a) consistent with the requirements of mandatory accreditation standards;

(b) consistent with SJGHC Patient Safety and Clinical Excellence Framework;

(c) of the highest quality;

(d) efficient; and

(e) consistent with the SJGHC Mission, Vision and Values, and Statement of Principles

by performing the following functions:

(f) advising the Hospital/Service CEO in relation to the delivery of Health Care Services within the Hospital/Service;

(g) assisting the Hospital/Service CEO to identify health needs within the community served by the Hospital/Service and advising on appropriate ways of meeting those needs;

(h) advising the Hospital/Service CEO on facilities, equipment and resources (including workforce resources) necessary for the provision of Health Care Services;

(i) advising the Hospital/Service CEO on issues related to the safety and quality of Health Care Services provided within the Hospital/Service;

(j) where applicable to the Hospital/Service, enabling the Hospital/Service CEO to complete the annual Attestation Statement required by the Austalian Commission on Safety and Quality in Health Care;

(k) promoting and participating in clinical quality improvement and risk management activities within the Hospital/Service;

(l) promoting education, teaching and research within the Hospital/Service;

(m) promoting productive working relationships between Medical Practitioners and the Hospital/Service;

(n) if requested by the Hospital/Service CEO, and in consultation with the Research Ethics Committee or other persons nominated by the Hospital/Service CEO, reviewing, monitoring and providing advice to the CEO in relation to indicators of care and clinical research;

(o) identifying and advising the Hospital/Service CEO on suitable Medical Practitioners as candidates for appointment as Emeritus Consultant; and

(p) such other functions as are conferred on it by the Hospital/Service CEO from time to time.

Membership of Medical Advisory Committee

8.3 The members of the Medical Advisory Committee shall be:

(a) the Hospital/Service DMS (where appointed);

(b) the person appointed from time to time as medical superintendent for the purpose of the mental health legislation of the jurisdiction in which the Hospital/Service is located; and

(c) such other Medical Practitioners and any other persons appointed by the Hospital/Service CEO on the basis that they have expertise, experience and/or perspectives that the Hospital/Service CEO believes should be represented on the Committee.

8.4 The Group DMS shall be an ex-officio member of the Medical Advisory Committee and be provided with the minutes of all meetings held.

Hospital/Service CEO

8.5 The Hospital/Service CEO may attend meetings of the Medical Advisory Committee but is not a member of that Committee.

Procedures of Medical Advisory Committee

8.6 The Hospital/Service CEO shall, in consultation with the Medical Advisory Committee as constituted from time to time:

(a) appoint a chairperson for the Committee; and

(b) determine:

(i) terms of reference for the Committee;

(ii) the rules and procedures for deliberations of the Committee;

(iii) requirements for the protection of confidentiality and privacy in deliberations of the Committee; and

(iv) such other matters relating to the proceedings of the Committee as the Hospital/Service CEO thinks fit.

9. SPECIALTY GROUPS AND CLINICAL DEPARTMENTS

Establishment of Specialty Groups and Clinical Departments

9.1 The Hospital/Service CEO, after consultation with the Medical Advisory Committee, may establish Specialty Groups and Clinical Departments.

Functions of Specialty Groups and Clinical Departments

9.2 The function of each Specialty Group and Clinical Department shall be, in respect of the Health Care Services provided by Medical Practitioners in the Group or Department, to:

(a) advise the Medical Advisory Committee and Hospital/Service CEO on relevant matters, including the need for and operation of rosters and lists of Medical Practitioners that provide such services, and the equipment and facilities required to provide them;

(b) promote and contribute to research;

(c) advise the Scope of Practice Committee on Authorised Scope of Practice requirements for the provision of such services;

(d) meet the requirements of mandatory accreditation standards;

(e) meet the obligations of the SJGHC Patient Safety and Clinical Excellence Framework; and

(f) develop and monitor programs of audit and quality improvement.

Membership of Specialty Groups and Clinical Departments

9.3 The members of each Specialty Group or Clinical Department shall be:

(a) the Hospital/Service DMS (where appointed) as an ex-officio member;

(b) all Medical Practitioners who are Accredited Medical Practitioners, employed or contracted from time to time to provide Health Care Services of the kind provided by Medical Practitioners in that Specialty Group or Clinical Department, except Supervised Practitioners; and

(c) any other persons appointed by the Hospital/Service CEO on the basis that they have expertise, experience and/or perspectives that the Hospital/Service CEO believes should be represented.

Hospital/Service CEO

9.4 The Hospital/Service CEO may attend meetings of the Specialty Groups or Clinical Departments but is not a member of such groups.

Procedures of Specialty Groups and Clinical Departments

9.5 The Hospital/Service CEO shall, in consultation with the Medical Advisory Committee as constituted from time to time, in relation to Specialty Groups and Clinical Departments:

(a) appoint a chairperson for the group; and

(b) determine:

(i) terms of reference for the group;

(ii) the rules and procedures for deliberations of the group;

(iii) requirements for the protection of confidentiality and privacy in deliberations of the group; and

(iv) such other matters relating to the proceedings of the group as the HospitalServices CEO thinks fit.

10. SCOPE OF PRACTICE COMMITTEE

Establishment of Scope of Practice Committee

10.1 A Scope of Practice Committee shall be established in each Hospital/Service.

Functions of Scope of Practice Committee

10.2 The Scope of Practice Committee shall be responsible for the following functions, in relation to Medical Practitioners (other than Supervised Practitioners) practising at the Hospital/Service:

(a) advising the Hospital/Service CEO in respect of the Credentials and proposed Authorised Scope of Practice of persons seeking to provide Health Care Services;

(b) reviewing the Credentials and Authorised Scope of Practice of Medical Practitioners providing Health Care Services, and making recommendations as appropriate;

(c) considering and advising the Hospital/Service CEO on requests or proposals for variation of the Authorised Scope of Practice by Medical Practitioners;

(d) considering and advising the Hospital/Service CEO on requests or proposals for the introduction of New Procedures by Medical Practitioners;

(e) providing general advice on issues relating to Credentials and Authorised Scope of Practice for Medical Practitioners; and

(f) such other functions as are conferred on it by the Hospital/Service CEO from time to time.

Membership of Scope of Practice Committee

10.3 The Hospital/Service CEO shall appoint the members of the Scope of Practice Committee. In doing so, the Hospital/Service CEO:

(a) shall appoint the Hospital/Service DMS (where appointed);

(b) may appoint members of the Medical Advisory Committee;

(c) must as far as practicable ensure that the principal specialty services provided by Medical Practitioners in the Hospital/Service are represented on the Committee (for which purpose the Hospital/Service CEO shall consult with the chairperson of the relevant Specialty Group or Clinical Department); and

(d) must if practicable, where a matter before the Committee relates to a specialty which is not represented on the Committee, appoint to the Committee, for the duration of its deliberation on the matter, a Medical Practitioner with skills and expertise in the relevant specialty.

Hospital/Service CEO

10.4 The Hospital/Service CEO may attend meetings of the Scope of Practice Committee but is not a member of that Committee.

Procedure of Scope of Practice Committee

10.5 The Hospital/Service CEO shall, with respect to the Scope of Practice Committee:

(a) appoint a member of the Committee to be the chair of the Committee;

(b) determine the rules and procedures for deliberations of the Committee;

(c) determine requirements for retention of records relating to deliberations of the Committee;

(d) determine requirements to ensure the protection of confidentiality and privacy in deliberations of the Committee; and

(e) determine such other matters relating the membership and proceedings of the Committee as the Hospital/Service CEO thinks fit.

Conflicts of Interest

10.6 A member of the Scope of Practice Committee must:

(a) not use his or her position as a member of the Committee to further a private interest or to gain an advantage or benefit for himself or herself or an entity in which he or she has an interest or to which he or she owes a fiduciary or legal duty;

(b) familiarise him or herself with the requirements of the *Competition and Consumer Act 2010 (Cth)* in relation to anti-competitive conduct;

(c) before attending the first meeting of the Committee, inform the chairperson of the Committee of any on-going interest or association of the member which might give rise to a Conflict of Interest in matters likely to come before the Committee;

(d) immediately notify the chairperson of the Committee if he or she becomes aware of any matter that is, or likely to come, before the Committee in which the member has or may have a Conflict of Interest or in which the member believes another member of the Committee has or may have a Conflict of Interest;

(e) excuse him or herself from the meeting of the Committee and any further participation in the making of a decision on the matter in relation to which the Conflict of Interest exists; and

(f) if he or she identifies a Conflict of Interest after the Committee has discussed the matter in which he or she has or may have a Conflict of Interest, immediately notify the Conflict of Interest to the chairperson of the Committee.

Further consideration where Conflict of Interest notified

10.7 Where a person notifies the chairperson of the Scope of Practice Committee in accordance with By-law 10.6(f):

(a) the chairperson must inform the next meeting of the Committee of the Conflict of Interest; and

(b) the Committee must, in the absence of the person who has or may have had the Conflict of Interest, reconsider its previous decision.

Report to Hospital/Service CEO

10.8 Where:

(a) the chairperson of the Scope of Practice Committee considers that a member of that Committee may have failed to comply with any of the requirements of By-law 10.6, the chairperson must report the matter to the Hospital/Service CEO who may take such action as he or she thinks appropriate; or

(b) a member of the Scope of Practice Committee considers that the chairperson of that Committee may have failed to comply with any of the requirements of By-law 10.6, the committee member must report the matter to the Hospital/Service CEO who may take such action as he or she thinks appropriate.

11. INDEMNITY FOR COMMITTEE MEMBERS

11.1 SJGHC shall, in respect of any person who is appointed in accordance with these By-laws to be a member of the Medical Advisory Committee ,the Scope of Practice Committee or Specialty Group or Clinical Department (or any sub-committee of such a committee) (each a 'relevant committee'), indemnify the person in respect of any liability the person incurs in respect of acts done or omissions or statements made by the person in good faith in the course of performing the functions of a relevant committee member.

PART III –PROVISION OF HEALTH CARE SERVICES

12. AUTHORITY TO PROVIDE HEALTH CARE SERVICES

Provision of Health Care Services

12.1 A person is not permitted to provide Health Care Services at a SJGHC Hospital/Service unless the person is:

(a) a Medical Practitioner who is:

(i) Accredited to provide such Health Care Services in accordance with these By-laws; or

(ii) Employed or Contracted to provide such Health Care Services; or

(b) a Procedural Assistant or Allied Health Care Professional who is assisting a Supervising Medical Practitioner in the provision of the Health Care Services in accordance with By-law 24.

Employed or Contracted Medical Practitioners

12.2 An Employed or Contracted Medical Practitioner's authority to provide Health Care Services is subject to:

(a) his or her Authorised Scope of Practice; and

(b) other terms and conditions of his or her contract, being the contract of Employment or Contract for Services respectively.

Accredited Medical Practitioners

12.3 An Accredited Medical Practitioner, in each Hospital/Service in respect of which he or she is Accredited:

(a) may provide Health Care Services; and

(b) has a licence to enter buildings and use equipment and facilities for the purpose of providing such Services—

subject to and in accordance with:

(c) the conditions and limitations applicable to his or her Category of Accreditation;

(d) his or her Authorised Scope of Practice for Health Care Services;

(e) his or her Conditions of Accreditation;

(f) the availability of sufficient and appropriate nursing, allied health and administrative staff or services where relevant;

(g) the resources, needs, expectations, priorities and commercial and strategic objectives of the Hospital/Service and SJGHC; and

(h) such other conditions, limitations or restrictions as may be imposed by the Hospital/Service CEO.

13. AUTHORISED SCOPE OF PRACTICE

13.1 The Hospital/Service CEO will determine the Authorised Scope of Practice for Medical Practitioners for the Hospital/Service.

13.2 In doing so, the Hospital/Service CEO must, except where inconsistent with these By-laws:

(a) apply the Credentialing Standard; and

(b) consult with and consider any recommendations provided by the Scope of Practice Committee.

Conditions and Limitations on Authorised Scope of Practice

13.3 The Hospital/Service CEO may impose conditions or limitations on the Authorised Scope of Practice of a Medical Practitioner by reference to any matter the Hospital/Service CEO considers relevant, including conditions or limitations relating to:

(a) the hospital and/or facilities at which the practices and/or procedures may be undertaken or performed;

(b) admission of patients;

(c) the range of practices and/or procedures that may be undertaken or performed;

(d) the number of practices and/or procedures that may be undertaken or performed in a specified period; and

(e) the supervision or audit of practices and/or procedures.

14. REVIEW OF CREDENTIALS AND AUTHORISED SCOPE OF PRACTICE

Hospital/Service CEO and DMS initiated reviews

14.1 The Hospital/Service CEO or Hospital/Service DMS may:

(a) request the Scope of Practice Committee; or

(b) engage an appropriately qualified independent person—

to undertake a review of the Credentials and/or Authorised Scope of Practice of a Medical Practitioner.

Scope of Practice Committee initiated reviews

14.2 The Scope of Practice Committee may also, on its own motion, undertake a review of the Credentials and/or Authorised Scope of Practice of a Medical Practitioner.

Scope of Practice Committee members must report matters requiring review

14.3 A member of the Scope of Practice Committee must bring to the attention of the Scope of Practice Committee any concerns he or she has relating to the Credentials or Authorised Scope of Practice of an Accredited, Employed or Contracted Medical Practitioner.

Practitioner must co-operate with review

14.4 A Medical Practitioner whose Credentials and/or Authorised Scope of Practice are subject to a review pursuant to By-law 14.1, or 14.2, must co-operate fully with the review, including by complying with all reasonable requests to meet and discuss with, and provide the information and documents requested by, the Committee or person conducting the review.

Review reports

14.5 As soon as practicable after a review of the Credentials and/or Authorised Scope of Practice of a Medical Practitioner under By-law 14.1 or 14.2 has been completed, a report of the findings of the review, together with any recommendations made by the person or Committee as to action to be taken in respect of the Medical Practitioner, must be provided to:

(a) the Medical Practitioner concerned; and

(b) the Hospital/Service CEO.

15. CHANGES TO AUTHORISED SCOPE OF PRACTICE

Temporary variation or limitation of Authorised Scope of Practice

15.1 The Hospital/Service CEO may, without first complying with By-law 15.3 temporarily vary or limit the Authorised Scope of Practice of a Medical Practitioner if the Hospital/Service CEO believes that it is necessary or desirable to do so to avoid or minimise a risk to the safety, health, wellbeing or welfare of any person, provided that:

(a) the Hospital/Service CEO must within a reasonable period after the temporary variation or limitation takes effect, comply with By-law 15.3 and decide whether the Authorised Scope of Practice should be varied or limited under By-law 15.2; and

(b) the temporary variation or limitation of the Authorised Scope of Practice shall take effect immediately and remain in force until a decision under By-law 15.2 takes effect.

Variation or limitation of Authorised Scope of Practice following review etc

15.2 The Hospital/Service CEO may, having complied with By-law 15.3, vary or limit the Authorised Scope of Practice of a Medical Practitioner if:

(a) a review under By-law 14.1 or 14.2 recommends the variation or limitation, or

(b) in the opinion of the Hospital/Service CEO, the variation or limitation is necessary:

(i) to maintain SJGHC's commitment to excellence in the provision of Health Care Services and avoid or minimise a risk to the safety, health, wellbeing or welfare of any person; or

(ii) to meet the clinical, commercial or strategic objectives, needs and priorities of the Hospital/Service and SJGHC; or

(iii) having regard to the availability of sufficient and appropriate resources (including beds, facilities, equipment and nursing, allied health and administrative staff and services) to support the provision of high quality patient care in accordance with the Authorised Scope of Practice.

15.3 Subject to By-law 15.1, the Hospital/Service CEO must not vary or limit the Authorised Scope of Practice of a Medical Practitioner unless the Hospital/Service CEO has first:

(a) where the grounds for the proposed action relate to the skills or competence of, or the standards of patient care provided by, the Practitioner—consulted with the Scope of Practice Committee; and

(b) given the Medical Practitioner written notice:

(i) setting out the action proposed to be taken;

(ii) setting out the grounds for taking the proposed action (including details of any relevant facts and/or allegations); and

(iii) stating that the Medical Practitioner may make a submission as to why the proposed action should not be taken and specifying a reasonable time (which must not be less than 14 days) within which the Medical Practitioner may do so; and

(c) had regard to any relevant matters put to him or her by the Medical Practitioner.

Notice

15.4 If the Hospital/Service CEO decides to vary or limit the Authorised Scope of Practice of a Medical Practitioner under By-law 15.2 the Hospital/Service CEO must give the Practitioner (with a copy to the Group DMS) notice setting out:

(a) the nature and effect of the action the Hospital/Service CEO has decided to take;

(b) the reasons for the action being taken;

(c) the date from which the action is to take effect;

(d) any things the Medical Practitioner must do to give effect to the action;

(e) where the action is to vary or limit the Authorised Scope of Practice, the steps (if any) that the Medical Practitioner must take in order to have the variation or limitation reversed; and

(f) the right of the Medical Practitioner to apply to an Appeals Committee for review of the decision under By-law 22.

16. SPECIFIC CONDITIONS ON PROVISION OF HEALTH CARE SERVICES

Research

16.1 Clinical research or research which is related to clinical practice may only be undertaken by a Medical Practitioner:

(a) in compliance with the requirements of:

(i) the Research Ethics Committee; and

(ii) any other applicable policy or procedures in relation to the conduct of research, and

(b) with the approval of the Hospital/Service CEO.

New procedures

16.2 The following provisions shall have effect with respect to the use of New Procedures for patients of SJGHC in the Hospital/Service:

(a) A Medical Practitioner must not undertake or use a New Procedure without the prior approval of the Hospital/Service CEO.

(b) A Practitioner who wishes to be authorised to undertake or use a New Procedure must submit a request to do so in the form, and containing such information, as is required by the Hospital/Service CEO or under any applicable policy or procedure.

(c) The Hospital/Service CEO must seek the advice of the Scope of Practice Committee in relation to any request to undertake a New Procedure.

(d) The Hospital/Service CEO may authorise the Medical Practitioner to undertake or use a New Procedure if he or she is satisfied that:

(i) the New Procedure is consistent with the clinical, commercial and strategic objectives of the Hospital/Service and SJGHC;

(ii) there is within the Hospital/Service the equipment, resources and staff necessary to support the use of the New Procedure; and

(iii) the Medical Practitioner's Authorised Scope of Practice should be varied to enable him or her to undertake or use the New Procedure.

16.3 In considering a request from the Hospital/Service CEO to provide advice in relation to a request to undertake or use a New Procedure, the Scope of Practice Committee may inform itself in any manner it sees fit, and without limitation may:

(a) consider peer reviewed literature and any other evidence as to the safety or effectiveness of the proposed New Procedure;

(b) have regard to the Credentials of the Medical Practitioner making the request;

(c) have regard to the likely effect on patient care, safety and clinical risk in the Hospital/Service if the New Procedure is approved;

(d) recommend that the use of the New Procedure be made subject to oversight, monitoring or audit or other restrictions or conditions; or

(e) refer the proposal to another body for advice (whether as to ethical issues or otherwise).

PART IV – ACCREDITATION OF MEDICAL PRACTITIONERS

17. APPLICATION FOR ACCREDITATION

Eligibility to seek Accreditation

17.1 A Medical Practitioner is eligible to be an Accredited Medical Practitioner if and only if he or she:

(a) is registered with the Relevant Registration Board;

(b) holds professional indemnity insurance in accordance with the requirements of the Relevant Registration Board;

(c) agrees to meet the applicable requirements of mandatory accreditation standards;

(d) agrees to uphold SJGHC's Patient Safety and Clinical Excellence Framework; and

(e) agrees to uphold SJGHC's Mission, Vision and Values and comply with the Statement of Principles.

Application to be made to Hospital/Service CEO

17.2 A Medical Practitioner who is eligible to be Accredited may apply for Accreditation in writing to the Hospital/Service CEO of the Hospital/Service in respect of which the Accreditation is sought.

Form and contents of application

17.3 An application for Accreditation must be made in writing in such manner and form (including electronically) as is approved by the Hospital/Service CEO in accordance with any guidelines issued by the Group DMS. The application must:

(a) specify the proposed Category of Accreditation;

(b) specify the proposed Authorised Scope of Practice;

(c) specify whether the applicant seeks the right to admit patients to the Hospital/Service;

(d) be accompanied by the information and documents set out in Schedule 5; and

(e) contain a declaration in the form set out in Schedule 7 signed by the applicant.

18. DETERMINATION OF APPLICATION FOR ACCREDITATION

(a) Hospital/Service requirements

18.2 An application for Accreditation will be considered if the Hospital/Service CEO determines that it is consistent with the clinical, commercial and strategic objectives, needs and priorities of the Hospital/Service and SJGHC.

Hospital/Service CEO may obtain further information

18.3 The Hospital/Service CEO may obtain such further information as he or she considers necessary to properly consider an application for Accreditation, including by:

(a) interviewing the applicant (in which the interview may be conducted by the Hospital/Service CEO or his or her nominee);

(b) requiring the applicant to provide further information or documents; and

(c) requiring the applicant to undergo a medical (including psychological) examination and provide a report as to the applicant's fitness to provide Health Care Services.

Hospital/Service CEO may consult

18.4 The Hospital/Service CEO may, in accordance with consent provided by the Applicant in accordance with Schedule 7, consult and discuss an application for Accreditation with any person or organisation he or she considers may be able to provide information relevant to the application, including:

(a) referees nominated by the applicant;

(b) the applicant's professional indemnity insurer;

(c) previous employers or their personnel nominated by the applicant;

(d) specialist medical colleges or professional associations of which the applicant is or has been a member;

(e) senior personnel of health services at which the applicant is or has been an Accredited Medical Practitioner;

(f) AHPRA or the Relevant Registration Board or similar regulatory or complaints body;

(g) the Hospital/Service CEO of any other SJGHC Hospital/Service by which the Applicant is or has previously been Accredited; and

(h) organisations responsible for providing criminal history and/or Working with Children checks.

Consultation with Committees

18.5 When considering an application for Accreditation, the Hospital/Service CEO:

(a) must consult with and seek advice from the Scope of Practice Committee in relation to the applicant's Credentials and proposed Authorised Scope of Practice; and

(b) may consult with and seek advice from the Medical Advisory Committee.

Consent to collect information

18.6 The Hospital/Service CEO may request that the applicant provide such further consents and authorisations as are necessary to enable the Hospital/Service CEO to obtain information or documents the Hospital/Service CEO thinks necessary for the purpose of properly considering the application. The Hospital/Service CEO may decline to consider the application further if the applicant refuses or fails to provide the consents or authorisations requested.

19. GRANT OF ACCREDITATION

Hospital/Service CEO may decide to grant or refuse Accreditation

19.1 Subject to By-law 19.6, the Hospital/Service CEO may decide that an application for Accreditation should be granted or refused.

Matters to be considered in deciding application

19.2 In deciding whether an application for Accreditation should be granted, (including in determining the Authorised Scope of Practice of an applicant) the Hospital/Service CEO may have regard to:

(a) SJGHC's commitment to excellence in the provision of Health Care Services;

(b) the clinical, commercial and strategic objectives, needs and priorities of the Hospital/Service and SJGHC;

(c) the availability of sufficient and appropriate resources (including beds, facilities, equipment and nursing, allied health and administrative staff and services) to support the provision of high quality patient care in accordance with the applicant's proposed Authorised Scope of Practice;

(d) the character, professional standing and reputation of the applicant;

(e) the applicant's membership of a specialist medical college or similar body, including the level of membership and any condition, restriction or suspension to which the membership is or has been made subject;

(f) the Credentials of the applicant;

(g) if the applicant is Accredited in another Hospital/Service, the conditions (including as to Authorised Scope of Practice) to which the Accreditation is subject, and the applicant's performance and conduct, at the other Hospital/Service;

(h) the applicant's accreditation to provide health care services, or scope of practice, at any other SJGHC Hospital/Service, or any other health service, hospital or day procedure centre, being suspended, varied or terminated (whether at the applicant's request or otherwise);

(i) any medical negligence claim made against, or arising out the conduct of, the applicant;

(j) whether the Practitioner has engaged in, or been notified to a Relevant Registration Board in relation to, Notifiable Conduct;

(k) whether the applicant is being investigated for or is found to have engaged in Professional Misconduct, Unprofessional Conduct or Unsatisfactory Professional Performance by a Relevant Registration Board, or any other registration, disciplinary, investigative or professional body makes an adverse finding against the applicant;

(l) whether the applicant has an Impairment that affects his or her capacity to provide Health Care Services to an appropriate standard of quality and safety;

(m) any criminal charge pending against the applicant at the date of the application, or any finding of guilt or criminal conviction recorded against the applicant within 10 years of the date of the application; and

(n) any other matter the Hospital/Service CEO considers to be relevant.

Accreditation specific to Hospital/Service

19.3 If the Hospital/Service CEO grants an application for Accreditation, the Accreditation is only applicable to, and any right or licence conferred by the Accreditation is only exercisable in, the Hospital/Service for which the Accreditation is granted.

Categories of Accreditation

19.4 If the Hospital/Service CEO decides that an application for Accreditation should be granted, the Hospital/Service CEO must determine that Accreditation be granted in one of the following Categories:

(a) Full Accreditation;

(b) Provisional Accreditation;

(c) Temporary Accreditation;

(d) Emeritus Accreditation—

provided that the applicant meets the pre-requisites applicable to the Category of Accreditation specified in Schedule 6, including the pre-requisite for Full Accreditation that the Practitioner has held Provisional Accreditation for at least one year, unless exempted by the Hospital/Service CEO.

Authorised Scope of Practice

19.5 If the Hospital/Service CEO decides that an application for Accreditation should be granted, the Hospital/Service CEO must determine an Authorised Scope of Practice in accordance with By-law 13.

Mandatory refusal of Accreditation

19.6 The Hospital/Service CEO must refuse an application for Accreditation if:

(a) the applicant is not registered with the Relevant Registration Board; or

(b) the applicant does not hold professional indemnity insurance as required by the Relevant Registration Board; or

(c) the applicant has not agreed to uphold the Mission, Vision and Values and comply with the Statement of Principles if Accredited.

Conditions of Accreditation

19.7 The Accreditation of an applicant shall be subject to:

(a) a condition that the applicant comply with these By-laws, including the Conduct Rules;

(b) the conditions and limitations applicable to the relevant Category of Accreditation set out in column 3 of Schedule 6; and

(c) any conditions or limitations on the applicant's Authorised Scope of Practice imposed under By-law 13.3; and

(d) any other conditions or limitations the Hospital/Service CEO considers appropriate.

Notification of decision to grant Accreditation

19.8 If the Hospital/Service CEO decides that Accreditation should be granted, he or she must give the applicant a written offer of Accreditation setting out:

(a) the Category of Accreditation;

(b) the Authorised Scope of Practice;

(c) the Accreditation Period;

(d) any conditions and limitations (other than those specified in these By-laws) to which the Accreditation is subject; and

(e) the fees (if any) payable with respect to the Accreditation.

Notification of decision to not grant Accreditation

19.9 If the Hospital/Service CEO decides not to Accredit an applicant, he or she must notify the applicant in writing of his or her decision.

Reasons not required

19.10 Without limiting By-law 4.3(b), the Hospital/Service CEO is not required to give reasons for any decision he or she makes or refuses to make in relation to an application for Accreditation under this By-law 19.

Acceptance of Accreditation

19.11 If an applicant wishes to accept an offer of Accreditation, he or she must do so in writing. The Applicant must confirm in his or her acceptance that he or she agrees to:

(a) uphold SJGHC's Mission, Vision and Values and comply with the Statement of Principles; and

(b) be bound by and comply with the By-laws, including the Conduct Rules; and

(c) be bound by and comply with any conditions or limitations to which the Accreditation is subject.

Commencement of Accreditation Period

19.12 Unless otherwise specified in the offer, the Accreditation Period commences on the date on which the applicant’s written acceptance, and any fee payable in respect of Accreditation, is received by the Hospital/Service CEO.

Extension or expansion of Authorised Scope of Practice

19.13 An Accredited Medical Practitioner who holds Full Accreditation may request a variation to his or her Authorised Scope of Practice that has the effect of expanding the range of Health Care Services that he or she is authorised to provide, by applying in writing to the Hospital/Service CEO specifying the variation sought and the reasons for seeking it. By-laws 18 and 19 shall apply to such a request, with any necessary modifications, as if the request for variation were an application for Accreditation.

Limitation of Authorised Scope of Practice by agreement

19.14 The Hospital/Service CEO and an Accredited Medical Practitioner may agree to a limitation of that practitioner's Authorised Scope of Practice, provided that the Hospital/Service CEO has first consulted with the Hospital/Service DMS, or if no Hospital/Service DMS is appointed, with the Scope of Practice Committee.

20. RE-ACCREDITATION

Application for Re-accreditation

20.1 An Accredited Medical Practitioner who holds Full Accreditation that is not suspended may apply for Re-accreditation in writing to the Hospital/Service CEO not less than thirty (30) days before the expiry of the current Accreditation Period.

Form and content of application

20.2 An application for Re-accreditation must be in the form approved by the Hospital/Service CEO and must be accompanied by:

(a) an updated curriculum vitae, setting out qualifications, clinical experience and all accreditations held at any other health care organisation since the previous application for Accreditation was submitted;

(b) any information or documents referred to in Schedule 5 that have changed since the previous application for Accreditation or Re-accreditation was submitted;

(c) any other information and/or documents specified by the Hospital/Service CEO; an

(d) a declaration in the form set out in Schedule 7, signed by the Accredited Medical Practitioner.

Consideration of application for Re-accreditation

20.3 By-laws 17, 18 and 19 of these By-laws apply, with any necessary modifications, to an application for Re-accreditation, as if it were an application for Accreditation.

Lapse of Accreditation

20.4 If an Accredited Medical Practitioner does not seek Re-accreditation prior to the expiration of the current Accreditation Period, the Accreditation shall cease on the last day of that Accreditation Period.

21. SUSPENSION AND TERMINATION OF ACCREDITATION

Temporary suspension of Accreditation

21.1 The Hospital/Service CEO may, without first complying with By-law 21.3, temporarily suspend the Accreditation of an Accredited Medical Practitioner if he or she has reason to believe that:

(a) the Practitioner:

(i) may not be registered by the Relevant Registration Board or has had such registration suspended or cancelled;

(ii) may not hold professional indemnity insurance as required by the Relevant Registration Board;

(iii) may have been charged with or found guilty by a court of a Serious Offence; or

(iv) may have been found by a Relevant Registration Board to have engaged in Professional Misconduct, Unprofessional Conduct or Unsatisfactory Professional Performance; or

(b) the suspension is necessary in order to avoid or minimise the safety, health, wellbeing or welfare of any person—

provided that:

(c) the Hospital/Service CEO must comply with By-law 21.3 within a reasonable period after the suspension takes effect and then decide whether the Accreditation should be suspended, varied or terminated under By-law 21.2; and

(d) the temporary suspension shall remain in force until a decision under By-law 21.2 takes effect.

Suspension, variation or termination of Accreditation

21.2 The Hospital/Service CEO may, having complied with By-law 21.3, suspend, vary or terminate an Accredited Medical Practitioner's Accreditation if:

(a) as a consequence of a variation or limitation of the Practitioner's Authorised Scope of Practice under By-law 15.2 the continued Accreditation of the Practitioner is inappropriate;

(b) the continued Accreditation of the Medical Practitioner would, in the opinion of the Hospital/Service CEO, be inconsistent with SJGHC's commitment to excellence in the provision of Health Care Services or contrary to the best interests of the Hospital/Service or the good standing and reputation of SJGHC;

(c) the services provided by the Medical Practitioner are, in the opinion of the Hospital/Service CEO, no longer consistent with or required for the clinical, commercial or strategic objectives, needs and priorities of the Hospital/Service or SJGHC;

(d) sufficient and appropriate resources (including beds, facilities, equipment and nursing, allied health and administrative staff and services) are no longer available to support the services provided by the Medical Practitioner;

(e) information provided by the Medical Practitioner in connection with an application for Accreditation or Re-accreditation is in the opinion of the Hospital/Service CEO false, misleading, inaccurate or incomplete;

(f) criminal charges are brought against the Medical Practitioner or a finding of guilt, or conviction for a criminal offence is recorded against the Medical Practitioner, or a Court determines that the Medical Practitioner has engaged in conduct which in the opinion of the Hospital/Service CEO is dishonest or involves moral turpitude;

(g) the Medical Practitioner is being investigated for or is found to have engaged in Professional Misconduct, Unprofessional Conduct or Unsatisfactory Professional Performance by a Relevant Registration Board, or any other registration, disciplinary, investigative or professional body makes an adverse finding against the Medical Practitioner;

(h) the Medical Practitioner has engaged in, or been notified to a Relevant Registration Board in relation to, Notifiable Conduct;

(i) the Medical Practitioner does not hold professional indemnity insurance as required by the Relevant Registration Board;

(j) the Medical Practitioner has an Impairment that affects his or her capacity to provide Health Care Services to an appropriate standard of quality and safety;

(k) the Medical Practitioner's accreditation to provide health care services, or scope of practice, at any other SJGHC Hospital/Service, or any other health service, hospital or day procedure centre, is suspended, varied or terminated (whether at the Medical Practitioner's request or otherwise);

(l) the Medical Practitioner has contravened these By-laws, the Conduct Rules or any other Conditions of Accreditation;

(m) the Medical Practitioner has provided Health Care Services (whether at SJGHC or elsewhere) in a manner that demonstrates a lack of commitment to SJGHC's Mission, Vision or Values or Statement of Principles or in the opinion of the Hospital/Service CEO is likely to impair SJGHC'S good standing and reputation; or

(n) where the Hospital/Service Chief Executive Officer has formed the opinion that:

(i) the Accreditation or continued Accreditation of the applicant would be contrary to the best interests of the Hospital/Service or its patients or patient care at the Hospital; or

(ii) there exists any other fact or circumstance which renders it inappropriate or undesirable that Accreditation of the Medical Practitioner be granted or continued.

21.3 Subject to By-law 21.1, the Hospital/Service CEO must not suspend, vary of terminate the Accreditation of an Accredited Medical Practitioner unless the Hospital/Service CEO has first:

(a) where the grounds for the proposed action relate to the skills or competence of, or the standards of patient care provided by, the Practitioner—consulted with the Scope of Practice Committee; and

(b) given the Medical Practitioner written notice:

(i) setting out the action proposed to be taken;

(ii) setting out the grounds for taking the proposed action (including details of any relevant facts and/or allegations); and

(iii) stating that the Medical Practitioner may make a submission as to why the proposed action should not be (or should not have been) taken and specifying a reasonable time (which must not be less than 14 days) within which the Medical Practitioner may do so; and

(c) had regard to any relevant matters put to him or her by the Medical Practitioner.

Notice

21.4 If the Hospital/Service CEO decides to suspend, vary or terminate the Accreditation of an Accredited Medical Practitioner under By-law 21.2—,

the Hospital/Service CEO must give the Practitioner (with a copy to the Group DMS) notice setting out:

(a) the nature and effect of the action the Hospital/Service CEO has decided to take;

(b) the reasons for the action being taken;

(c) the date from which the action is to take effect;

(d) any things the Medical Practitioner must do to give effect to the action;

(e) where the action is to suspend the Accreditation, the steps (if any) that the Medical Practitioner must take in order to have the suspension lifted; and

(f) the right of the Medical Practitioner to apply to an Appeals Committee for review of the decision under By-law 22.

Formal warning in lieu of suspension of Accreditation

21.5 If the Hospital/Service CEO considers that grounds for varying, suspending or terminating Accreditation may exist but in the particular circumstances, variation, suspension or termination is not warranted, the Hospital/Service CEO may give the Accredited Medical Practitioner a formal written warning in lieu of that other action. However, if an Accredited Medical Practitioner has been given formal warnings under this By-law on two or more previous occasions, the Hospital/Service CEO must act to vary, suspend or terminate the Accreditation of the Medical Practitioner as is appropriate.

Effect of suspension of accreditation

21.6 An Accreditation Period shall not be extended by any period during which a Medical Practitioner's Accreditation is suspended under these By-laws, and during any such period of suspension the Medical Practitioner shall have no rights to provide Health Care Services in the Hospital/Service.

22. APPEAL OF DECISIONS

Decisions which may be appealed

22.1 Subject to By-law 22.2, this By-law 22 applies to a decision of the Hospital/Service CEO:

(a) to vary, suspend or terminate Accreditation;

(b) to vary or limit the Authorised Scope of Practice of an Accredited Medical Practitioner;

(c) to refuse to Re-accredit an Accredited Medical Practitioner; and

(d) to Re-accredit an Accredited Medical Practitioner on conditions (including as to Authorised Scope of Practice) that are less favourable than the terms and conditions applying at the time the application for Re-accreditation is made.

Certain decisions not appealable

22.2 This By-law 22 does not apply to, and there is no right of appeal in respect of, a decision to:

(a) refuse to grant Provisional Accreditation or Temporary Accreditation;

(b) impose conditions or limitations on Provisional Accreditation or Temporary Accreditation;

(c) vary or limit the Authorised Scope of Practice of a Medical Practitioner who holds Temporary Accreditation or Provisional Accreditation.

(d) suspend or terminate the Temporary Accreditation or Provisional Accreditation of a Medical Practitioner;

(e) refuse to grant Full Accreditation after a period of Provisional Accreditation;

(f) impose conditions or limitations on, or to specify an Accreditation Period of less than three years for, Full Accreditation;

(g) temporarily vary or limit the Authorised Scope of Practice in accordance with By-law 15.1;

(h) temporarily suspend Accreditation of a Medical Practitioner in accordance with By-law 21.1;

(i) suspend or terminate the Accreditation of a Medical Practitioner, or refuse to Re-accredit a Medical Practitioner, on the grounds that the Medical Practitioner:

(i) does not hold professional indemnity insurance as required by the Relevant Registration Board; or

(ii) is not registered by the Relevant Registration Board, or has had such registration suspended or cancelled.

Application for appeal

22.3 Within thirty (30) days of being notified of a decision which may be appealed under this By-law 22, the Medical Practitioner may appeal in writing to the Group DMS for review of the decision. The application must:

(a) set out the full name and contact details of the Medical Practitioner;

(b) be accompanied by a copy of the notice given under By-law 15.4 or 21.4;

(c) state the grounds of appeal; and

(d) indicate whether the Medical Practitioner intends to be legally represented in the appeal.

22.4 No application for appeal may be made, and no Appeal will be entertained, if the application is made more than thirty (30) days after the Medical Practitioner is notified of the decision to which the appeal relates.

Appeals Committee

22.5 Upon receiving notice of an appeal under By-law 22.3, the Group DMS must establish an Appeals Committee as soon as is practicable to consider the appeal and make recommendations to the Group DMS.

Constitution of Appeals Committee

22.6 An Appeals Committee shall comprise:

(a) a person nominated by the Group DMS, as Chair; and

(b) either (2) two or four (4) other persons appointed at the discretion of the Group DMS (having regard to the subject matter of the appeal),

provided that:

(c) where the appeal is in respect of a decision that concerns the Credentials or Authorised Scope of Practice of the Medical Practitioner a majority of members of the Appeals Committee shall be Medical Practitioners with experience in the relevant discipline or area of practice;

(d) the following persons must not be members of the Appeal Committee:

(i) the Hospital/Service CEO;

(ii) if the decision being appealed was made as a consequence of a review of the Credentials and/or Authorised Scope of Practice of the Medical Practitioner - any person who was a member of the Scope of Practice Committee that undertook that review; and

(iii) any person who the Group DMS reasonably believes has a Conflict of Interest arising out of any matter connected with the appeal.

Procedure of Appeals Committee

22.7 The Appeals Committee must conduct its proceedings and inform itself as it thinks fit, subject to the following requirements:

(a) The Appeals Committee must commence to hear the appeal as soon as practicable after it is established.

(b) The appeal must be conducted with as little formality and technicality as proper consideration of the subject matter permits.

(c) Any decision of the Appeals Committee shall be by a majority vote or consensus;

(d) The appellant Medical Practitioner and the Hospital/Service CEO or his or her nominee may be invited to appear, and to make oral and/or written submissions where relevant to the appeal.

(e) As soon as practicable after reaching a decision, the Chair of the Appeals Committee must forward the Appeals Committee's recommendation to the Group DMS, who shall determine the appeal.

Group DMS to decide appeal

22.8 As soon as practicable after receiving the recommendation of the Appeals Committee, the Group DMS must decide whether to accept that recommendation and must promptly give notice of his or her decision on appeal to:

(a) the Medical Practitioner who instituted the appeal; and

(b) the Hospital/Service CEO who made the decision appealed against.

Group DMS decision final

22.9 The decision of the Group DMS is final and shall not be subject to further appeal or review by any tribunal or court of law.

Indemnity for Appeals Committee Members

22.10 SJGHC shall, in respect of any person who is appointed in accordance with these By-laws to be a member of the Appeals Committee, indemnify the person in respect of any liability the person incurs in respect of acts done or omissions or statements made by the person in good faith in the course of performing the functions as a member of the Appeals Committee.

23. INFORMATION

Confidentiality of Accreditation-related information

23.1 Subject to these By-laws, any information obtained by the Hospital/Service CEO, any committee and any other person in connection with the Accreditation, determination of Authorised Scope of Practice or any other decision or action

under these By-laws shall be treated as confidential and must not be disclosed except:

(a) for the purpose of making or implementing decisions made in accordance with these By-laws;

(b) in connection with the governance or management of the Hospital/Service or any other Hospital/Service of SJGHC;

(c) with the consent of the person to whom it relates;

(d) for the purpose of disclosing Notifiable Conduct or making a voluntary notification under the National Law; or

(e) as otherwise required or authorised by Law.

24. ASSISTANTS AND STUDENTS OF ACCREDITED MEDICAL PRACTITIONERS

24.1 This By-Law 24 only applies to the provision of Health Care Services to patients of SJGHC by Accredited Medical Practitioners, who will for the purpose of this by-law be defined as the **Supervising Medical Practitioner**.

Procedural Assistants

24.2 A Medical Practitioner may be assisted in the carrying out of Surgical Procedures by a Procedural Assistant, provided that the following requirements are complied with:

(a) The Procedural Assistant may only assist in the provision of Health Care Services which are within the Authorised Scope of Practice of the Supervising Medical Practitioner.

(b) The Supervising Medical Practitioner must have personally assessed the competence and performance of the Procedural Assistant and be satisfied that the Procedural Assistant is competent and suitable to provide the assistance.

(c) The Supervising Medical Practitioner must have personally verified, by sighting relevant documentation, that:

(i) the Procedural Assistant is registered with, and holds professional indemnity insurance in accordance with the requirements of, the Relevant Registration Board; or

(ii) if the Procedural Assistant is not required to be registered with any registration board, that the acts and omissions of the Assistant are covered by appropriate professional indemnity insurance.

(d) The Supervising Medical Practitioner must:

(i) have obtained the prior written approval of the Hospital/Service CEO or his or her nominee to the use of the Procedural Assistant; and

(ii) comply, and ensure that the Procedural Assistant complies, with any conditions to which that approval is made subject.

(e) The Supervising Medical Practitioner remains responsible for all Health Care Services provided by the Procedural Assistant and must provide effective and adequate supervision of the Procedural Assistant at all times.

(f) The Supervising Medical Practitioner must hold professional indemnity insurance that covers the Supervising Practitioner's supervision of the Procedural Assistant.

(g) The Supervising Medical Practitioner must ensure that contemporaneous records are maintained (in accordance the requirement of the Hospital/Service) of all Health Care Services provided by or with the assistance of the Procedural Assistant.

(h) The Procedural Assistant must comply with any direction or requirement of the Hospital/Service CEO or any policies or procedures of the Hospital/Service in relation to the use of Procedural Assistants.

Allied Health assistance

24.3 By-Law 24.4 applies to the engagement of Allied Health Professionals directly by Supervising Medical Practitioners, and is not applicable to services provided by Allied Health Professionals who are employed or contracted directly by SJGHC.

24.4 A Supervising Medical Practitioner may be assisted in the provision of Health Care Services by an Allied Health Professional, provided that:

(a) the Supervising Medical Practitioner must have personally verified, by sighting relevant documentation, that:

(i) the Allied Health Professional is registered with, and holds professional indemnity insurance in accordance with the requirements of, the Relevant Registration Board; or

(ii) if the Allied Health Professional is not required to be registered with any registration board, that the acts and omissions of the Allied Health Professional are covered by appropriate professional indemnity insurance.

(b) the Supervising Medical Practitioner must:

(i) have obtained the prior written approval of the Hospital/Service CEO or his or her nominee to the use of the Allied Health Professional; and

(ii) comply, and ensure that the Allied Health Professional complies, with any conditions and Hospital/Service Procedures to which that approval is made subject.

(c) The Supervising Medical Practitioner must ensure that contemporaneous records are maintained (in accordance with the requirement of the Hospital/Service) of all Health Care Services provided by or with the assistance of the Allied Health Professional.

(d) The Allied Health Professional must comply with any direction or requirement of the Hospital/Service CEO or any policies or procedures of the Hospital/Service in relation to the use of Allied Health Professionals pursuant to this By-law.

Students

24.5 A Supervising Medical Practitioner may be accompanied by a Student while providing Health Care Services provided that the following requirements are complied with:

(a) The Student must either be:

(i) enrolled to undertake training at an Approved Institution; or

(ii) specifically approved by the Hospital/Service CEO to attend the Hospital/Service.

(b) The Student may only accompany the Supervising Medical Practitioner in providing services which are within the Authorised Scope of Practice of the Supervising Medical Practitioner.

(c) The Supervising Medical Practitioner must provide effective and adequate supervision of the Student at all times.

(d) The Supervising Medical Practitioner must ensure that contemporaneous records are maintained (in accordance with the requirement of the Hospital/Service) of all Health Care Services provided with the participation or involvement of the Student.

(e) The Supervising Medical Practitioner must comply with any direction or requirement of the Hospital/Service CEO or any policies or procedures of the Hospital/Service in relation to the use of Student.

(f) For any Student who is not from an Approved Institution, the Supervising Medical Practitioner must:

(i) obtain the prior written consent of the Hospital/Service CEO or his or her nominee, in accordance with any requirements specified by the Hospital/Service CEO, for the Student to enter the Hospital/Service; and

(ii) certify that his or her acts and omissions in relation to the Student, and the acts and omissions of the Student, are covered by appropriate professional indemnity insurance.

Directions in relation to use of assistants and students

24.6 A Medical Practitioner must take all reasonable steps to ensure that any direction issued by the Hospital/Service CEO to or concerning any or all Procedural Assistants, Allied Health Professionals or Students, is promptly complied with, including a direction that:

(a) a particular Medical Practitioner or class of Medical Practitioner must not use Assistants or Students or directly engage Allied Health Professionals; or

(b) a particular Medical Practitioner or class of Medical Practitioner may not be a Procedural Assistant or;

(c) a particular Allied Health Professional or class of Allied Health Professional may not be engaged directly by an Accredited Practitioner to assist in providing Health Care Services;

(d) Procedural Assistants or Allied Health Professionals shall not provide specified Health Care Services, or Health Care Services in specified circumstances;

(e) a Student is not to be involved in specified activities or not enter specified places or areas;

(f) a Procedural Assistant, Student or an Allied Health Professional engaged pursuant to By-Law 24.4 must immediately leave the SJGHC premises.

SCHEDULE 1 - DEFINITIONS AND INTERPRETATION

1. Definitions

In these By-laws, unless stated or necessarily implied to the contrary:

Accreditation means authorisation to provide Health Care Services within a Hospital/Service under these By-laws. **Accredited** and **Accredit** have corresponding meanings.

Accredited Medical Practitioner means a practitioner who:

(a) has independent practising rights;

(b) has specialist credentials;

(c) is Accredited to provide to provide Health Care Services within a Hospital/Service under these By-laws, rather than being Employed or Contracted.

Accreditation Period means the period for which a Medical Practitioner is accredited, being the lesser of the period specified in Schedule 6 for the relevant Category of Accreditation or the period (if any) determined by the Hospital/Service CEO in deciding to grant Accreditation.

AHPRA means the Australian Medical Practitioner Regulation Agency established under the National Law.

Allied Health Professional means a Health Care Professional other than a Medical Practitioner, Nurse or Midwife.

Appeals Committee means the committee established to review Accreditation-related decisions in accordance with By-law 22.

Approved Institution means a training or education institution with which SJGHC has a written agreement in place to cover the placement of students of the institution at a SJGCH facility for training purposes.

Australian Commission on Safety and Quality in Health Care means the Commonwealth entity established under the *National Health Reform Act 2011* (Cth) and the *Public Governance, Performance and Accountability Act 2013* (Cth), jointly funded by all governments which works with consumers, providers and stakeholders of health care to achieve a sustainable, safe and high quality health system.

Authorised Scope of Practice means the clinical practices, services and procedures (including the performance of procedures and use of techniques) which a Medical Practitioner is authorised to conduct, provide or perform within a Hospital/Service – in relation to patients of SJGHC.

By-laws means these By-laws as amended and in force from time to time.

Category of Accreditation means a category referred to in Schedule 6 in which a Medical Practitioner is Accredited in accordance with By-law 19.4.

Conflict of Interest means an actual, potential or perceived conflict and includes a conflict arising out of:

(a) an office or position held by a person;

(b) a legal, fiduciary or ethical duty held by a person; and/or

(c) a legal or equitable interest held by a person in any property or undertaking.

Conditions of Accreditation means the conditions to which the Accreditation of a Medical Practitioner is subject, in accordance with By-law 19.7.

Conduct Rules means the rules for the conduct of Accredited Medical Practitioners set out in Schedule 4.

Contract for Services means the contract for services by which a Contracted Medical Practitioner is contracted by SJGHC to provide Health Care Services within a Hospital/Service**.**

Contracted Medical Practitioner means a Medical Practitioner contracted by SJGHC under a Contract for Services.

Credentials means the qualifications, professional training, clinical experience and training and experience in leadership, research, education, communication and teamwork that contribute to a Medical Practitioner's competence, performance and professional suitability to provide safe, high quality health care services.

Credentialing Standard means the *National Standard for Credentialing and Defining the Scope of Clinical Practice of Medical Practitioners in Public or Private Hospitals* published by the Australian Council for Safety and Quality in Health Care in 2004, as updated from time to time.

Hospital/Service means a SJGHC facility or campus where Health Care Services are provided, including:

(a) a hospital, hospice or other healthcare facility:

  (i) owned or operated by SJGHC, or

  (ii) operating under the name of, or associated by name with, SJGHC; or

(b) any premises where SJGHC is the landlord or licensor.

Hospital/Service CEO means the person for the time being holding the position (however described) of Chief Executive Officer of a Hospital/Service.

Hospital/Service DMS means the person for the time being holding the position of Director of Medical Services, however described, and whether or not combined with another position, responsible for management and oversight of medical services within a Hospital/Service.

Employed means employed by SJGHC to provide Health Care Services within a Hospital/Service. **Employ** and **Employment** have corresponding meanings.

Employed Medical Practitioner means a Medical Practitioner employed SJGHC to provide Health Care Services within a Hospital/Service.

Governing Board means the governing board of SJGHC.

Group CEO means the person for the time being holding the position (however described) of Chief Executive Officer of SJGHC.

Group DMS means the person holding the position of Director of Medical Services, (however described) responsible for the oversight of medical services at SJGHC.

Health Care Professional means a person who is registered in a health profession in accordance with the National Law.

Health Care Services means the full range of health services that may be provided by a Medical Practitioner to a patient, and includes:

(a) admission of patients to SJGHC facilities; and

(b) provision of health services to patients admitted to SJGHC facilities; and

(c) provision of health services through programs operated by SJGHC to patients in their homes and other community settings;

(d) provision of health services to State-funded patients in outpatients clinics operated by SJGHC; and

(e) provision of health care to patients through consulting rooms or clinics.

Impairment has the meaning it has in the National Law.

Law means an Act of the Commonwealth or of a State or Territory and all ordinances, regulations and other legislative instruments made thereunder.

Medical Advisory Committee (MAC) means the medical advisory committee of a Hospital/Service established in accordance with By-law 8.

Medical Practitioner means a person registered as a Medical Practitioner or Dentist under the National Law, and includes Accredited and Employed and Contracted Medical Practitioners unless specified otherwise.

National Law means the Medical Practitioner Regulation National Law as in force in a State or Territory from time to time.

National Safety and Quality Health Services Standards means the standards developed by the Australian Commission on Safety and Quality in Health Care (second edition) to protect the public from harm and improve the quality of health service provision as amended from time to time.

National Standards for Mental Health Services specific standards for Mental Health services developed by the Austalian Commission on Safety and Quality in Health Care, released in 2010 and as amended from time to time.

New Procedure means a clinical service, procedure, technique or other intervention that:

(a) involves more than incremental change in the way in which Health Care Services are delivered (irrespective of whether or not it is innovative, complex or costly); and

(b) is being introduced into a SJGHC Hospital/Service for the first time, regardless of whether it:

  (i) has been established in another organisation or Hospital/Service; or

  (ii) is deemed by a responsible body of professional opinion to be one that will benefit patients.

Notifiable Conduct has the meaning it has in the National Law, being the grounds for mandatory notification to AHPRA.

Patient Safety & Clinical Excellence Framework means the document produced by SJGHC which describes the way in which clinical governance is operationalised as amended from time to time.

Personal Information has the meaning given to it in the *Privacy Act 1988 (Cth)*.

Procedural Assistant means a Medical Practitioner or other person who is authorised in accordance with By-law 24.2 to assist a Medical Practitioner with the provision of Surgical Procedures.

Professional Misconduct has the meaning it has in the National Law.

Provisional Accreditation means Accreditation granted under clause 19.4 in the Category of Provisional Accreditation.

QIC Health and Community Services Standards means the accreditation standards developed by Quality Innocation Performance Limited applicable to services with a community focus as amended from time to time.

Re-accreditation means Accreditation for a further period immediately upon the expiry of a prior period of Accreditation.

Relevant Registration Board means the board or other body by which a Medical Practitioner or other Health Care Professional is required to be registered under

the National Law in order to provide Health Care Services that the Health Care Professional provides.

Research Ethics Committee means the ethics committee established by SJGHC in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* (2007) as updated from time to time.

Scope of Practice Committee means the Committee established under By-law 10.

Serious Offence means:

(a) an offence that may be tried upon indictment; or

(b) a summary offence punishable by a term of imprisonment of more than two (2) years.

SJGHC means St John of God Health Care Inc (ARBN 051 960 911).

SJGHC Mission, Vision and Values means the mission, vision and values of SJGHC, as set out in Schedule 2 of these By-laws and as amended from time to time.

Statement of Principles means the Ethical Standards – Statement of Principles, as set out in Schedule 3 of these By-laws and as amended from time to time.

Student means a medical student or other person who is undertaking but has not completed training as a Medical Practitioner, and is therefore not registered or eligible to be registered under the National Law as a Medical Practitioner (other than on a student register).

Surgical Procedures means surgical and interventional procedures conducted in operating theatres, catheterisation laboratories and similar areas.

Supervised Practitioner means a Medical Practitioner who is not entitled to provide Health Care Services at SJGHC except under the supervision of another Medical Practitioner, and includes a Procedural Assistant, resident medical officer, intern, and registrar.

Supervising Practitioner means an Accredited Medical Practitioner who is assisted by a Procedural Assistant or an Allied Health Professional, or who is accompanied by a Student, in accordance with By-law 24.

Temporary Accreditation means Accreditation granted under clause 19.4. in the Category of Provisional Accreditation.

Unprofessional Conduct has the meaning it has in the National Law.

Unsatisfactory Professional Performance has the meaning it has in the National Law.

2. Interpretation

In these By-laws:

(a) words importing the singular include the plural and vice-versa;

(b) reference to a person of one gender includes a person of the other gender;

(c) month or monthly includes calendar month or calendar monthly;

(d) reference to an Act includes all regulations, ordinances or by-laws made under that Act; and

(e) references to statutes, regulations, ordinances or by-laws includes all statutes, regulations, ordinances or by-laws amending, consolidating or replacing them.

SCHEDULE 2 - MISSION, VISION AND VALUES

Mission

Our Mission is to continue the healing mission of Jesus Christ through the provision of services that promote life to the full by enhancing the physical, emotional, intellectual, social and spiritual dimensions of being human.

The Mission will be implemented by:

1. developing a person centred culture where the innate dignity of each person is valued and upheld;
2. providing services of the highest standards, identifying and responding to unmet health care needs in the local community, in partnership with its valued health professionals;
3. holding Mission as the driving force by which decisions are made; and acquiring, allocating, and distributing resources justly, responsibly and in a sustainable manner;
4. being an inclusive and innovative organisation where well-formed leaders are developed and grounded in the Values, Mission and ethos of SJGHC's Ministry.

Vision

The Vision of SJGHC is that we live and proclaim the healing touch of God's love where we invite people to discover the richness and fullness of their lives, give them a reason to hope, and a greater sense of their own dignity.

Christian health care is distinctive by being based on the healing mission of Jesus. At St John of God Health Care our aim is to bring comfort through healing services that are caring, compassionate and affirming. Our ultimate goal is to give people a reason for hope and a feeling of greater self-confidence and dignity. We promote a holistic approach to caregiving, which respects the dignity and worth of each human person. We believe that healing is enhanced by an environment that nurtures the physical, emotional, intellectual, social and spiritual wellbeing of those in our care.

Values

The core values that guide us are:

1. **Hospitality** - a welcoming openness to all; to the familiar and the mystery of self, people, ideas, experiences, nature and to God.
2. **Compassion** - feeling with others in their discomfort or suffering, striving to understand the other's experience, with a willingness to reach out in solidarity.
3. **Respect** - the attitude which treasures the unique dignity of every person, and recognises the sacredness of all creation.
4. **Justice** - a balanced and fair relationship with self, our neighbour, all of creation and with God.
5. **Excellence** - giving the optimum standard of care and service within the scope of available resources.

SCHEDULE 3 - ETHICAL STANDARDS – STATEMENT OF PRINCIPLES

In their provision of Health Care Services at a SJGHC Hospital/Service, Health Care Professionals are required to respect and comply with the moral teachings of the Catholic Church in respect to present day health care as set out in the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia 2001 (as amended from time to time). Without limiting the obligations set out in the above Code, Practitioners must comply with the following requirements.

Holistic care

Catholic health services should care for all patients conscientiously and devotedly, recognising that life is sacred from conception until natural death. The total good of the patient is the primary concern of the Catholic health care ministry. It is therefore required that the highest standards of competence and excellence in care be employed in the treatment of patients.

The spiritual welfare of a person is an integral part of a patient's care. Therefore chaplains and pastoral practitioners are considered members of the health team and must be given every assistance in ministering to the welfare of the patient. Every patient has the right to request that the minister of his or her choice be asked to visit him or her.

After death the body is to be attended with respect and dignity.

The next of kin/guardian of the patient, with the patient's consent, should be kept promptly, reliably and courteously informed regarding the patient's condition.

In vitro fertilisation

No health care professional may participate in any procedure of reproductive technology that is not consistent with Catholic moral teaching.

Sterilisation

Sterilisation procedures, whether permanent or temporary, for men or women, are not to be performed as a means of contraception. Treatments or medications which produce temporary or permanent sterility may be prescribed when they are morally justified.

Termination of pregnancy

Abortion that is the directly intended killing of the foetus before viability is never permitted, nor are Health Care Services that would have the effect of causing the death of a foetus, unless those services are necessary for the treatment of a pathological condition of the mother and cannot be safely postponed until the foetus is viable.

Operations, treatments and medications which do not directly intend to effect termination of pregnancy but which have as their purpose the necessary treatment of a pathological condition of the mother are permitted when they cannot be safely postponed until the foetus is viable, even though they may result in the death of the foetus.

Physician-assisted suicide and euthanasia

Euthanasia is a person's deliberate act or omission which has the intention of ending a patient's life. Physician-assisted suicide occurs when a health care professional intentionally enables a patient to end his or her own life, for the purpose of ending pain and/or suffering that the patient considers intolerable.
At a SJGHC Hospital/Service, participating in or facilitating a process with the sole intention of ending a patient's life (including prescribing and administering lethal drugs or assessing a patient for this purpose), is not permitted. Other care decisions which

are not intended to cause death, but may risk, or actually cause, the shortening of life (e.g. the administering of appropriate pain relief and the withdrawal of burdensome treatments) are permitted.

Organ Transplants

The transplant of organs from living donors is morally permissible provided the loss of such organs does not deprive the donor of life itself, or of the functional integrity of the body. All such procedures require appropriate free and informed consent, referable to both donor and recipient.

Referral when in doubt

If any doubt or question arises as to whether any practice infringes or is contrary to the teachings, laws and traditions of the Catholic Church then the Practitioner shall refer the matter to the Hospital/Service CEO or his/her nominee.

SCHEDULE 4 - CONDUCT RULES

Definitions

1. For the purpose of these Conduct Rules:

   (a) the term **Practitioner** means any Health Care Professional who is obliged to comply with the Conduct Rules in the SJGHC Medical Practitioner By-Laws; and

   (b) all other capitalised definitions are as defined in the SJGHC Medical Practitioner By-Laws.

Standards of conduct

2. The Practitioner must at all times observe the highest standards of personal and professional conduct. Without limiting this requirement, the Practitioner must:

   (a) comply with any reasonable request made by the Hospital/Service CEO with regard to personal conduct and the provision of services at SJGHC;

   (b) adhere to the generally accepted ethics of professional practice in relation to colleagues, caregivers, staff, patients and their families and the SJGHC Mission, Vision and Values and Statement of Principles;

   (c) comply with all applicable Laws;

   (d) comply with all applicable requirements of the mandatory accreditation standards and all SJGHC quality standards;

   (e) comply with the obligations of the SJGHC Patient Safety and Clinical Excellence Framework;

   (f) comply with any obligations imposed on the Practitioner under the By-laws, including these Conduct Rules; and

   (g) practise his or her profession in accordance with all applicable codes of conduct, policies, procedures and protocols established by SJGHC or the Hospital/Service from time to time.

3. Without limiting Clause 1, the Practitioner must comply with all laws and rules, policies and procedures in relation to:

   (a) occupational health and safety;

   (b) anti-discrimination, bullying and harassment;

   (c) confidentiality, privacy and the management of personal and health information; and

   (d) working with children.

4. The Practitioner must, if requested to do so at any time by the Hospital/Service CEO, provide to the Hospital/Service CEO or his or her nominee such consents or authorisations as are necessary to enable a criminal history, working with children, identity, compliance or qualification check to be conducted with the appropriate authorities and institutions.

SJGHC brand and reputation

5. The Practitioner must not, except where the Practitioner is an Employee and is authorised to do so under his or her terms of Employment, without the express written authorisation of the Hospital/Service CEO:

   (a) use the SJGHC logo or letterhead;

   (b) use the word 'SJGHC' in connection with their private practice (except for the purposes of locating the address of the practice); or

(c) represent that he or she is an employee or contractor of SJGHC.

6. The Practitioner must not take any action, engage in any conduct or make any statements which cause or may cause SJGHC embarrassment or humiliation or otherwise adversely affect its good standing and reputation.

Mission, Vision, Values and Ethical Standards

7. The Practitioner must:

(a) respect and comply with the moral teachings of the Catholic Church, and must at all times uphold the SJGHC Mission, Vision and Values and comply with the Statement of Principles.

(b) refer the matter to the Hospital/Service CEO if any doubt or question arises as to whether any practice infringes or is contrary to the principles referred to in (a).

Withdrawal of treatment

8. Where the withdrawal of treatment is considered because there appears to be no reasonable prospect of the patient obtaining further benefit from continued treatment or because it appears that continued treatment is likely to constitute an undue burden to the patient, the Practitioner must act in compliance with:

(a) any SJGHC policy related to withdrawal of treatment, when providing care to patients of SJGHC;

(b) any instructions given by the patient; and

(c) the Statement of Principles.

Authority to practice

9. The Practitioner must:

(a) maintain professional registration with the Relevant Registration Board and any other licences or authorisations required for the conduct of his or her practice; and

(b) furnish annually to SJGHC, and at other times when requested to do so, documentary evidence of such registration, licenses or authorisations.

10. Except as authorised by the By-laws, the Practitioner must not aid or facilitate the provision of Health Care Services by persons who are not Accredited Practitioners or Employed or Contracted Practitioners.

Clinical practice

11. The Practitioner must provide Health Care Services:

(a) in accordance with and only to the extent permitted by the Practitioner's Authorised Scope of Practice;

(b) in compliance with all applicable clinical protocols of the Hospital/Service, or of the relevant department or specialty group;

(c) in accordance with any applicable requirements of a relevant specialist medical college;

(d) where the Practitioner is required to obtain the consent of or to consult with a clinical committee, only after having obtained the consent of, or consulted with, the relevant committee; and

(e) where the Practitioner is required to provide the services or conduct procedures under supervision, only with such supervision as is required.

Admission of patients

12. The Practitioner must not admit a patient unless the Practitioner is authorised to do so by the terms of his or her Employment, Contract for Services or Accreditation.

Patient consent

13. Except where it is necessary to do so to save life in an emergency or where otherwise required by law, the Practitioner must not undertake a procedure on a patient of SJGHC without first obtaining the informed consent of:

    (a) where the patient is capable of giving consent—the patient; and

    (b) where the patient is incapable of giving consent—the patient's guardian or legal representative—

    in accordance with the policy or procedures specified from time to time by SJGHC or the Hospital/Service.

New Procedures

14. The Practitioner:

    (a) must not conduct a New Procedure without first obtaining the approval of the Hospital/Service CEO in accordance with the By-laws; and

    (b) must comply with all conditions, limitations, policies or other requirements that apply to the conduct of the New Procedure.

Insurance

15. The Practitioner must, for any Health Care Services provided (other than as an Employee of SJGHC):

    (a) maintain medical indemnity insurance in accordance with the requirements of the Relevant Registration Board and any other standards approved from time to time by the Hospital/Service CEO; and

    (b) furnish annually to the Hospital/Service CEO, and at other times when requested to do so, documentary evidence that the required insurance, including the level of cover, is maintained.

Patient care

16. Where a Practitioner admits a patient under his or her care, that Practitioner must comply with SJGHC's policies regarding minimum standards of attendance on patients. Without limiting his or her obligations arising under such policies, the Practitioner must:

    (a) attend all newly admitted patients within 24 hours of admission;

    (b) attend patients as often as is necessary to ensure safe, high quality patient care;

    (c) use all reasonable means to keep every patient under his or her care fully informed of his or her condition, management and progress, and to respond to reasonable requests for information from nominated family members;

    (d) be available, or deputise another appropriately qualified Accredited, Employed or Contracted Practitioner, for emergency calls to his or her patients;

    (e) make appropriate arrangements (including by ensuring that a suitably qualified Accredited, Employed or Contracted Practitioner is available) for patient care when the Practitioner is ill, on leave or otherwise unable to attend their patients;

(f) participate in formal on-call and after hours availability arrangements as required by the Hospital/Service CEO from time to time; and

(g) ensure his or her availability when deputising for another Accredited or Employed Practitioner.

Record keeping

17. The Practitioner must:

(a) maintain medical records sufficient to meet professional obligations for safe patient care in the format and in accordance with the Code of Good Medical Practice 2014 and standards required by SJGHC;

(b) observe all applicable Laws, standards, policies and procedures relating to the protection of privacy or the management of health records.

Infection control

18. The Practitioner must:

(a) comply with the SJGHC policy in relation to infection control, including guidelines in relation to Practitioner infection with blood-borne viruses;

(b) be familiar with and comply with the guidelines regarding infection with blood-borne/vaccine-preventable disease published by the Relevant Registration Board; and

(c) where practising in Western Australia, provide evidence that he or she has a methicillin-resistant staphylococcus aureus (MRSA) clearance if he or she has worked or been a patient in any hospital or residential care facility outside of Western Australia in the last 12 months;

Safety and quality activities

19. The Practitioner shall contribute as required to continuous improvement in the quality and safety of Health Care Services provided by SJGHC. Without limiting this requirement, the Practitioner must:

(a) participate in clinical quality activities of the Hospital/Service, and of his or her clinical department, specialty or peer review group, as required;

(b) co-operate fully in audit and quality activities concerning patients of SJGHC to whom he or she provides Health Care Services, including by providing access to clinical material pertaining to individual patient care and participating in mortality and morbidity reviews and audits of practice and procedures;

(c) participate as required in clinical registries operated by the Hospital/Service or in which the Hospital/Service is a participant;

(d) maintain confidentiality of information concerning clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services within the Hospital/Service;

(e) meet the obligations of the SJGHC Patient Safety and Clinical Excellence Framework;

(f) meet the requirements of the mandatory accreditation standards to assist the Hospital/Service to achieve and maintain all relevant accreditations;

(g) bring to the attention of the Hospital/Service CEO circumstances where the Practitioner considers that Health Care Services provided within the Hospital/Service could be improved;

(h) notify the Hospital/Service CEO where the Practitioner becomes aware of a complaint made in respect of the conduct of the Hospital/Service or the quality of care provided by it; and

(i) notify the Hospital/Service CEO where the Practitioner becomes aware of any incident or circumstance which could to claims being brought against the Hospital/Service on the grounds of negligence, want of care or a failure to provide safe working conditions.

Training and educational activities

20. The Practitioner must:

(a) undertake such mandatory training as SJGHC or the Hospital/Service may require in order to ensure patient safety and compliance with the requirements of mandatory certification standards. The Hospital/Service Director of Medical Services may, on application by a Practitioner, recognise prior learning or the completion of relevant CPD requirements in place of the mandatory training on a case by case basis. Such recognition is entirely at the discretion of the Hospital/Service Director of Medical Services and must be supported by Practitioner supplied evidence;

(b) comply with reasonable requests to participate in the education and training of medical and other professional staff of SJGHC and of students attending SJGHC, including facilitating the availability of patients for clinical teaching (subject to any instructions by either the treating Practitioner or the senior nurse and informed consent being given by the patient);

(c) as appropriate, and when reasonably required to do so, attend and participate in clinical meetings, seminars, lectures and other training programmes as may be provided by or held at the Hospital/Service; and

(d) participate in continuing professional development required as a condition of registration under the National Law; and

(e) provide sufficient evidence to exhibit compliance with this clause 20.

Continuous reporting

21. The Practitioner must immediately provide written notification to the Hospital/Service CEO of any matter or circumstance that have, or may reasonably be expected to have, a material bearing upon his or her:

(a) right to practise;

(b) Authorised Scope of Practice; or

(c) ability to deliver health care services to patients safely and effectively; and

(d) in addition, in the case of Accredited Practitioners, his or her:

(i) professional indemnity insurance status and/or coverage; or

(ii) eligibility to be Accredited.

22. Without limiting the scope of the obligation in clause 21, the Practitioner must notify the Hospital/Service CEO immediately he or she becomes aware that:

(a) an incident has occurred which could give rise to an allegation that there has been negligence or a breach of duty of care or a want of care on the part of the Practitioner;

(b) a report of Notifiable Conduct on the Practitioner's part has been made to the AHPRA;

(c) the Relevant Registration Board has:

(i) commenced an inquiry into the Practitioner's conduct;

(ii) required the Practitioner to undergo a health assessment or performance assessment;

(iii) made an adverse finding against the Practitioner;

(iv) required the Practitioner to give an undertaking;

(v) cautioned the Practitioner;

(vi) imposed a condition, limitation or restriction in relation to the Practitioner's registration; or

(vii) suspended or cancelled the registration of the Practitioner;

(d) any other registration, disciplinary, investigative or professional body has made an adverse finding against the Practitioner;

(e) the Practitioner's Accreditation to provide health care services and/or authorised scope of practice, at any other Hospital/Service, health service, hospital or day procedure centre is suspended, varied or terminated, whether at the Practitioner's request or otherwise;

(f) the Practitioner suffers an illness or disability which may adversely affect his or her ability to provide health services safely;

(g) the Practitioner is charged with or found guilty of a criminal offence;

(h) the Practitioner ceases to hold professional indemnity insurance in accordance with the requirements of the Relevant Registration Board, or there is any material change to the level of or conditions associated with professional indemnity insurance held by the Practitioner; or

(i) the Practitioner becomes aware of any matter or circumstance which gives rise to or may give rise to a Conflict of Interest between the Practitioner and SJGHC.

SCHEDULE 5 - INFORMATION TO BE SUBMITTED BY APPLICANTS

1. The applicant's full name, title, mailing and email addresses and telephone contact numbers.
2. A full curriculum vitae, setting out the applicant's qualifications, clinical experience and former and current appointments.
3. Evidence of identity in accordance with:
   (a) the prescribed verification procedure (100) point check pursuant to the Financial Transaction Reports Act 1988 (Cth); or
   (b) such other identification procedure as is specified by the Hospital/Service CEO.
4. Two recent passport-standard photographs.
5. Originals or certified copies of all diplomas, degrees and recognised post-graduate qualifications.
6. The names and contact details of three referees who possess recent knowledge of the applicant's qualifications and professional skills and experience.
7. Proof of registration by the Relevant Registration Board to practise in the jurisdiction where Accreditation is sought.
8. Information about the applicant's membership of a specialist medical college or similar body, including the level of such membership and any conditions, restriction or suspension to which such membership is or has been made subject.
9. Evidence that the applicant holds current professional indemnity insurance in accordance with the requirements of the Relevant Registration Board.
10. A statement disclosing any past, pending or anticipated:
    (a) medical negligence claim made against, or arising out the conduct of, the applicant;
    (b) notification to, investigation of, or disciplinary action taken against, the applicant by a Relevant National Board or other health care regulatory or complaints body; and
    (c) variation, limitation, suspension or termination of practice rights or accreditation at any other Hospital/Service or other health care institution.
11. A current:
    (a) National Police Certificate; and
    (b) where appropriate, or required by the Hospital/Service CEO or policy, having regard to the proposed Authorised Scope of Practice, Working With Children check.
12. A statement disclosing:
    (a) any pending or anticipated criminal proceedings; and
    (b) any findings of guilt or criminal convictions recorded or civil penalties imposed within 10 years of the date of the application.
13. A statement disclosing any infection with a blood-borne virus that is likely to affect clinical practice in accordance with the proposed Authorised Scope of Practice.
14. Details of any matter or circumstance which might give rise to a Conflict of Interest between the Accredited Practitioner and SJGHC.

15. Any other information that may be specified by the Hospital/Service due to requirements particular to the relevant jurisdiction.

16. A signed declaration in the form of Schedule 7.

SCHEDULE 6 - CATEGORIES OF ACCREDITATION

Category	Prerequisites	Conditions and limitations	Accreditation Period
Full Accreditation	Medical Practitioner is not subject to a requirement of the Relevant Registration Board to practice under supervision. Practitioner must have held Provisional Accreditation for at least one year or been exempted by the Hospital/Service CEO from the requirement to hold Provisional Accreditation.	As determined by the Hospital/Service CEO.	3 calendar years from the date of appointment, or such lesser period as may be determined by the Hospital/Service CEO.
Provisional Accreditation	Medical Practitioner is not subject to a requirement of the Relevant Registration Board to practice under supervision. The Hospital/Service CEO considers that the Medical Practitioner should undertake a period of Provisional Accreditation in order to enable his or her suitability for Full Accreditation to be confirmed.	No right to appeal if Provisional Accreditation revoked, suspended or varied, or if an application for Full Accreditation made after a period of Provisional Accreditation is not granted. Other conditions / limitations as determined by the Hospital/Service CEO.	A period determined by the Hospital/Service CEO but not exceeding one (1) year.
Temporary Accreditation	Medical Practitioner is not subject to a requirement of the Relevant Registration Board to practice under supervision. HospitalServices CEO must have determined that Accreditation on an emergency, locum or other short term basis is in the interests of the Hospital/Service or of a patient.	No right to appeal if Temporary Accreditation revoked, suspended or varied. Other conditions / limitations as determined by the Hospital/Service CEO.	A period determined by the Hospital/Service CEO but not exceeding six (6) months.
Emeritus Consultant	Medical Practitioner is not subject to a requirement of the Relevant Registration Board to practice under supervision. Medical Practitioner is an Accredited Medical Practitioner nominated by the Medical Advisory Committee as a distinguished member of his or her profession who has provided meritorious service	No authority to admit patients. Subject to Authorised Scope of Practice, may provide consulting advice to other Accredited or Employed or Contracted Medical Practitioners. Other conditions / limitations as	A period determined by the Hospital/Service CEO but not exceeding one (1) year.

	to the Hospital, his or her profession or the community.	determined by the Hospital/Service CEO.	

SCHEDULE 7 - DECLARATION, ACKNOWLEDGMENT AND CONSENT

I [*INSERT NAME AND ADDRESS OF APPLICANT*] DECLARE that the information provided by me in connection with this application for Accreditation / Re-accreditation is accurate and complete.

I ACKNOWLEDGE AND AGREE THAT:

A decision to grant my application for Accreditation / Re-accreditation, to impose Conditions of Accreditation, to define my Authorised Scope of Practice or to suspend, vary, limit or terminate my Accreditation and/or Authorised Scope of Practice is wholly within the discretion of the Hospital/Service CEO;

I do not have any right to, interest in or legitimate expectation of a grant of Accreditation or to particular Conditions of Accreditation or Authorised Scope of Practice;

I do not have any right to, interest in or legitimate expectation of my Accreditation being maintained, or of being Re-accredited at all or with the same Conditions and Authorised Scope of Practice, save for the rights expressly conferred under the By-laws;

The By-laws exist for the purpose of maintaining SJGHC Mission, Vision and Values and ensuring compliance with the Statement of Principles, the achievement of SJGHC's business and strategic objectives and the continuous improvement in the safety and quality of Health Care Services provided at SJGHC. They do not confer on me or any Medical Practitioner any legally enforceable rights, or create in any Medical Practitioner any legitimate expectation in relation to any matter or thing referred to in them.

I CONSENT to the Hospital/Service CEO or his or nominee for the purpose of considering my application disclosing Personal Information about me to, and collecting Personal Information about me, within SJGHC and from:

My nominated referees;

My medical or professional indemnity insurer(s);

Previous employer(s) or their personnel identified in my application;

Senior personnel of health services at which I am currently, or was previously, accredited;

A specialist medical college or professional association of which I am or have previously been a member;

AHPRA or the Relevant Registration Board or similar regulatory or complaints body;

Any organisation responsible for conducting or providing criminal history checks; and

Any organisation responsible for conducting or providing Working with Children checks.

I AGREE that if Accredited, I will:

uphold SJGHC's Mission, Vision and Values;

comply with the Statement of Principles;

comply with and be bound by the Conduct Rules and other Conditions of Accreditation;

comply with all other obligations of an Accredited Medical Practitioner under the By-laws.

Signed by the Medical Practitioner