Unitas Healthcare Pty Ltd
Hospital By-laws

To be interpreted with Hospital By-laws Annexures document

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Unitas Healthcare Pty Ltd
Hospital By-laws

Part A Authority

1. Authority for the By-laws

1.1 These By-laws are made by resolution of the board of Unitas Healthcare and apply to each Hospital operated by a Unitas Healthcare Group Company.

1.2 These By-laws may be amended from time to time by resolution of the board of Unitas Healthcare.

1.3 These By-laws specify Unitas Healthcare's requirements and processes with respect to:

1.3.1 accreditation, credentialing and defining the Scope of Clinical Practice of Accredited Practitioners;

1.3.2 the Medical Advisory Committee of each Hospital and the involvement of the medical staff in the clinical governance of the Hospital; and

1.3.3 the obligations and responsibilities of Accredited Practitioners.

2. Contractual effect of the By-laws

2.1 In consideration of the rights and privileges conferred on an Accredited Practitioner by the granting of accreditation under these By-laws:

2.1.1 an applicant for accreditation must irrevocably undertake, and by making an application for accreditation will be taken to have irrevocably undertaken, to comply with these By-laws; and

2.1.2 on granting of accreditation under these By-laws, these By-laws will take effect as a contract between the Hospital Licensee and an Accredited Practitioner.

2.2 An amendment to these By-laws under By-law 1.2 will be taken to amend the contract formed by the operation of By-law 2.1 on the later of:

2.2.1 the date specified by Unitas Healthcare as to when the relevant amendment will take effect; and

2.2.2 the date on which the relevant amendment is notified to Accredited Practitioners.

2.3 For the purpose of By-law 2.2.2 and without limiting any other way by which notice may be given, notice of amendment to these By-laws may be given by prominent reference to the relevant amendment in a communication or publication circulated amongst Accredited Practitioners generally.

3. Governing Law

The contract formed between the Hospital Licensee and an Accredited Practitioner in accordance with By-law 2.1.2 is governed by the law of the state in which the Hospital is located.

Part B Interpretation

4. Definitions

In these By-laws:

accreditation means the conferral of status as an Accredited Practitioner under these By-laws.

Accredited Practitioner means:

(a) a Medical Practitioner or Dentist authorised in accordance with these By-laws to treat patients at a Hospital within a defined Scope of Clinical Practice; and

(b) where the context permits, includes an Allied Health Practitioner.[1]

Adjudication Body has the meaning given in the Health Practitioner Regulation National Law.

Allied Health Application means the application form approved by a Hospital from time to time for use by an Allied Health Practitioner to apply for accreditation at that Hospital.

Allied Health Practitioner means a Health Practitioner, other than a Medical Practitioner or Dentist, in a health profession recognised by the Hospital Licensee including the health professions of occupational therapy, physiotherapy, podiatry, pharmacy and psychology.

By-laws means these by-laws as amended from time to time.

Chief Executive Officer means the person appointed by the board of Unitas Healthcare as the senior executive of a Hospital including, where the context permits, a person authorised by the board of Unitas Healthcare to act in that position.

Dentist means a person registered under the Health Practitioner Regulation National Law in the dental health profession.

Director of Nursing means the person responsible for the management and delivery of nursing services in a Hospital (howsoever the position is named) including, where the context permits, a person authorised by the Hospital Licensee to act in that position. The Director of Nursing may also be the Chief Executive Officer.

General Conditions means the general conditions of accreditation applying to each Accredited Practitioner set out in Attachment 1.

General Practitioner means a Medical Practitioner registered under the Health Practitioner Regulation National Law in the specialty of general practice.

[1] The application of these By-laws to Allied Health Practitioners is addressed in Attachment 2.

Health Practitioner has the meaning given in the Health Practitioner Regulation National Law.

Health Practitioner Regulation National Law means the Act in the State or Territory in which the Hospital is located which implements the *Health Practitioner Regulation National Law*.

Hospital means a hospital or health care facility operated within Australia by a Unitas Healthcare Group Company.

Hospital Licensee means the Unitas Healthcare Group Company that holds the licence in respect of a Hospital under the Licensing Act.

Hospital Medical Officer means an Accredited Practitioner who is employed by a Hospital or contracted for service by a Hospital to assist Specialist Practitioners in the care of patients.

Human Research Ethics Committee means an ethics committee constituted in accordance with National Health and Medical Research Council *National Statement on Ethical Conduct in Human Research*.[2]

impairment has the meaning given in the Health Practitioner Regulation National Law.

Licensing Act means the act in the state in which the Hospital is located concerning the licensing of private hospitals and private health facilities including the *Health Services Act 1988* (Vic) and *Health Services (Health Service Establishments) Regulations* 2013 (Vic).

Medical Advisory Committee means the medical advisory committee of a Hospital constituted in accordance with these By-laws.

Medical Application Form means the application form approved by a Hospital from time to time for use by a Medical Practitioner or Dentist to apply for accreditation at the Hospital.

Medical Practitioner means a person registered under the Health Practitioner Regulation National Law in the medical health profession.

National Board has the meaning given in the Health Practitioner Regulation National Law and includes, relevantly:

(a) the Medical Board of Australia; and

(b) the Dental Board of Australia.

Privacy Laws means the *Privacy Act 1988* (Cth) and such other legislation or binding schemes applicable to a Hospital and/or Accredited Practitioners relating to the privacy of personal information and health records.

Relevant Event has the meaning given in section 130 of the Health Practitioner Regulation National Law, being in relation to a registered health practitioner:

(i) the practitioner is charged, whether in a participating jurisdiction or elsewhere, with an offence punishable by 12 months imprisonment or more;

(ii) the practitioner is convicted of or the subject of a finding of guilt for an offence, whether in a participating jurisdiction or elsewhere, punishable by imprisonment;

[2] *National Statement on Ethical Conduct in Human Research 2007* (Updated 2018).

(iii) appropriate professional indemnity insurance arrangements are no longer in place in relation to the practitioner's practice of the profession;

(iv) the practitioner's right to practise at a hospital or another facility at which health services are provided is withdrawn or restricted because of the practitioner's conduct, professional performance or health;

(v) the practitioner's billing privileges are withdrawn or restricted under the *Medicare Australia Act 1973* of the Commonwealth because of the practitioner's conduct, professional performance or health;

(vi) the practitioner's authority under a law of a State or Territory to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines is cancelled or restricted;

(vii) a complaint is made about the practitioner to an entity referred to in section 219(1)(a) to (e) of the Health Practitioner Regulation National Law; or

(viii) the practitioner's registration under the law of another country that provides for the registration of health practitioners is suspended or cancelled or made subject to a condition or another restriction.

Scope of Clinical Practice means the extent of clinical practice that an Accredited Practitioner is authorised to undertake at a Hospital based on the Accredited Practitioner's credentials, competence, performance and professional suitability and the needs and capability of that Hospital to support the Accredited Practitioner's clinical practice.

Special Conditions means conditions of accreditation, other than General Conditions, determined to apply:

(a) on initial accreditation of an Accredited Practitioner;

(b) on review of an Accredited Practitioner's Scope of Clinical Practice; or

(c) on reinstatement of an Accredited Practitioner's accreditation following suspension of accreditation.

Specialist Practitioner means a Medical Practitioner recognised as a specialist or consultant physician, in their nominated specialty, for the purpose of the *Health Insurance Act 1973* (Cth).

Surgical Assistant means a Medical Practitioner accredited under these By-laws to assist one or more Accredited Practitioners in an operating theatre in a Hospital.

Unitas Healthcare means Unitas Healthcare Pty Ltd ACN 635 424 814.

Unitas Healthcare Group Company means Unitas Healthcare and its related bodies corporate.

Unitas Healthcare Group Policy means a policy or procedure determined by Unitas Healthcare to apply to one or more Hospitals.

Working With Children Act means the act in the state in which the Hospital is located concerning the clearance requirements for working with children including the *Worker Screening Act 2020* (Vic).

5. General Interpretation

5.1 Words and headings

In these By-laws, unless expressed to the contrary:

5.1.1 words denoting the singular include the plural and vice versa;

5.1.2 the word 'includes' in any form is not a word of limitation;

5.1.3 where a word or phrase is defined, another part of speech or grammatical form of that word or phrase has a corresponding meaning; and

5.1.4 headings and sub-headings are for ease of reference only and do not affect the interpretation of these By-laws.

5.2 Specific references

In these By-laws, unless expressed to the contrary, a reference to:

5.2.1 a gender includes all other genders;

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

5.2.3 any document (such as a deed, agreement or other document), policy, directive, practice standard, position, statement or guideline is to that item (or, if required by the context, to a part of it) as amended, novated, substituted or supplemented at any time;

5.2.4 writing includes writing in digital form;

5.2.5 'these By-laws' is to these By-laws as amended from time to time;

5.2.6 'A$', '$', 'AUD' or 'dollars' is a reference to Australian dollars;

5.2.7 a clause, schedule or attachment is a reference to a clause, schedule or attachment in or to these By-laws;

5.2.8 any body (**Original Body**) which no longer exists or has been reconstituted, renamed, replaced or whose powers or functions have been removed or transferred to another body or agency, is a reference to the body which most closely serves the purposes or objects of the Original Body.

5.3 Severability

5.3.1 Any provision of these By-laws that is held to be illegal, invalid, void, voidable or unenforceable must be read down to the extent necessary to ensure that it is not illegal, invalid, void, voidable or unenforceable.

5.3.2 If it is not possible to read down a provision as required by this By-laws, the provision will be severed from these By-laws and the remaining provisions will have continuing operation.

5.4 Titles

In these By-laws where there is use of the title "chairperson" the incumbent of that position for the time being may choose to use whichever designation that person so wishes.

Part C Accreditation

6. Accreditation as a prerequisite to admission and treatment of patients

6.1 A Medical Practitioner or Dentist is only permitted:

6.1.1 to admit a patient to a Hospital; and/or

6.1.2 to treat a patient at a Hospital,

if the Medical Practitioner or Dentist is accredited under these By-laws as an Accredited Practitioner at that Hospital.

6.2 An Accredited Practitioner may only admit a patient to a Hospital if the Accredited Practitioner's Scope of Clinical Practice includes the admission of patients to that Hospital.

6.3 An Accredited Practitioner may only treat patients within the Accredited Practitioner's Scope of Clinical Practice.

6.4 Accreditation as an Accredited Practitioner does not give the Accredited Practitioner:

6.4.1 any right or entitlement to access a Hospital (or any facility in a Hospital);

6.4.2 any right or entitlement to any operating session or list;

6.4.3 any right or entitlement to admit patients to a Hospital;

6.4.4 any right or entitlement to availability of beds to admit patients to a Hospital; or

6.4.5 any right or entitlement to referral of patients.

6.5 By-law 6.4 does not affect any other legally enforceable agreement between an Accredited Practitioner and a Unitas Healthcare Group Company with respect to the subject matter of By-law 6.4.

7. Contracted service providers

7.1 A contract for the provision of clinical services by a contracted service provider to patients of a Hospital (such as a contract with a diagnostic imaging or pathology provider), may:

7.1.1 provide that only Medical Practitioners who have been accredited as an Accredited Practitioner at the Hospital may provide the clinical services; or

7.1.2 require the contracted service provider to ensure that:

(a) the qualifications, professional training, skills and experience and the current status and history with respect to registration, disciplinary action and insurance of each Medical Practitioner who provides clinical services are verified by the contracted service provider in accordance with Unitas Healthcare policy and the requirements of the contract; and

(b) each Medical Practitioner who provides clinical services does so only within the Scope of Clinical Practice which is specified in the contract unless the

relevant Medical Practitioner has been specifically accredited by the Hospital with a modified Scope of Clinical Practice in accordance with these By-laws.

7.2 In the circumstances contemplated by By-law 7.1.2, the Medical Practitioner will be taken to be an Accredited Practitioner for the purpose of these By-laws.

7.3 Accreditation of a Medical Practitioner who provides clinical services on behalf of a contracted service provider is conditional on the contract with the contracted service provider remaining in force. The Medical Practitioner has:

7.3.1 no right of, or entitlement to, ongoing accreditation on the termination or expiry of the relevant contract; and

7.3.2 no right of appeal against the termination or expiry of accreditation pursuant to this By-law.

7.4 The Chief Executive Officer of a Hospital may suspend or terminate the accreditation (or deemed accreditation under By-law 7.2) of a Medical Practitioner who provides clinical services on behalf of a contracted service provider. Except as may be provided in the relevant contract, there is no right of appeal against the suspension or termination of accreditation pursuant to this By-law.

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8. Categories of Accredited Practitioners

8.1 Each person accredited as an Accredited Practitioner must be accredited in one of the following categories:

8.1.1 Specialist Practitioner;

8.1.2 General Practitioner;

8.1.3 Hospital Medical Officer;

8.1.4 Surgical Assistant; or

8.1.5 Dentist.

8.2 Subject to By-laws 8.3 and 8.4, Accredited Practitioners accredited in the categories of General Practitioner, Hospital Medical Officer and Surgical Assistant are not permitted to admit patients to a Hospital.

8.3 Subject to the policy of the relevant Hospital, a Hospital Medical Officer may initially admit patients on the basis that treatment will subsequently be undertaken by an Accredited Practitioner whose Scope of Clinical Practice includes the admission of patients for the required treatment (desirably within 48 hours of admission of the patient).

8.4 The Hospital Licensee may authorise a General Practitioner to admit patients to a Hospital in its absolute discretion. Without limiting any other provision of these By-laws, such authorisation:

8.4.1 may be limited to admissions to particular units of that Hospital and/or admissions for particular categories of patients;

8.4.2 may be limited by reference to patient acuity or other relevant criteria; and

8.4.3 be subject to such conditions as the Hospital Licensee determines.

9. Granting Accreditation

9.1 Granting accreditation – general

Accreditation as an Accredited Practitioner is granted by the Hospital Licensee based on the recommendations of the Medical Advisory Committee.

9.2 Term of accreditation

9.2.1 An Accredited Practitioner is accredited under these By-laws for the term determined by the Hospital Licensee.

9.2.2 The maximum term of accreditation is a period of 3 years.

9.2.3 The Hospital Licensee may determine a standard period of accreditation for any group or cohort of Accredited Practitioners at the Hospital such that the accreditation of each Accredited Practitioner in the group or cohort expires at the same time. Where the Hospital Licensee does so:

(a) if an Accredited Practitioner is appointed at the commencement of the standard period, the term of accreditation will be the standard period determined by the Hospital Licensee under this By-law; and

(b) if an Accredited Practitioner is accredited during the standard period of accreditation, the term of accreditation will be the remainder of the standard period determined by the Hospital Licensee under this By-law.

9.3 Hospital Medical Officers

Accreditation as a Hospital Medical Officer automatically ceases if the Hospital Medical Officer ceases to be employed or contracted for service by the Hospital.

9.4 Accreditation at will

Unless otherwise determined by the Hospital Licensee, accreditation in the category of General Practitioner and Surgical Assistant is at will and may be terminated by the Chief Executive Officer without cause at any time. Termination of accreditation will not be treated as termination of accreditation for the purpose of By-law 17.

10. Application for Accreditation

10.1 Process

The process for accreditation of Accredited Practitioners is set out in By-law 10.2.

10.2 Medical Practitioners and Dentists

10.2.1 A Medical Practitioner or Dentist seeking accreditation as an Accredited Practitioner (the **Applicant**) at a Hospital must complete a Medical Application Form and provide the form to the Chief Executive Officer. The Chief Executive Officer (or delegate) must make available a copy of these By-laws.

10.2.2 The Applicant must provide such documentation and information as required by the Medical Application Form (or as otherwise required by the relevant Hospital Licensee)) and must, and by submitting a Medical Application Form will be taken to:

(a) authorise the Hospital Licensee to obtain information relevant to the Applicant's application for accreditation from third parties (including the Applicant's medical indemnity insurer, registration authorities, referees and hospitals and health facilities at which the Applicant currently or has previously worked);

(b) authorise the Hospital Licensee to undertake a background check for the purposes of the Working With Children Act, or other legislation with similar objectives, where required by law or Hospital policy;

(c) authorise the Hospital Licensee to cooperate with other any other hospital or health facility in relation to any investigation, enquiry or process relevant to the Applicant's suitability to practice at the Hospital or any other hospital or health facility; and

(d) undertake to comply with these By-laws in accordance with By-law 2.1.

10.2.3 The Chief Executive Officer must consider the application in the context of the Hospital's business plans and objectives and may make any enquiries or consultation relevant to that consideration as he or she thinks fit. The Chief Executive Officer must then determine whether the application is to be given further consideration pursuant to By-laws 10.2.4 to 10.2.7 below. If the Chief Executive Officer determines that that the application will not be given further consideration, the Chief Executive Officer is not required to give reasons to the Applicant.

10.2.4 If the Chief Executive Officer determines that the application is to be given further consideration he or she:

(a) may require the Applicant to attend an interview;

(b) must consult referees nominated by the Applicant; and

(c) must refer the Applicant's Medical Application Form, and any other information that he or she considers relevant, to the Hospital's Medical Advisory Committee.

10.2.5 A Medical Advisory Committee must consider an application having regard to:

(a) an Applicant's qualifications, professional training, skills and experience;

(b) an Applicant's current status and history with respect to professional registration, disciplinary action and insurance;

(c) an Applicant's character and good standing with his or her peers (including the Applicant's demonstrated ability and willingness to work cooperatively with the Hospital's management and the medical and clinical staff of the Hospital);

(d) the Hospital's facilities and capability in the context of the accreditation and Scope of Clinical Practice sought;

(e) guidelines and policies with respect to credentialing and defining of the Scope of Clinical Practice applicable and relevant to the application;[3]

(f) where relevant (for example, where an Applicant has declared an impairment), the Applicant's physical and mental health in the context of the accreditation and Scope of Clinical Practice sought; and

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[3] See **Error! Reference source not found.** and **Error! Reference source not found.**.

(g) where an Applicant is currently, or has previously been, an Accredited Practitioner, the Applicant's demonstrated clinical performance, participation in clinical review and quality assurance activities and cooperation with the Hospital's management and the medical and clinical staff of the Hospital.

10.2.6 The Medical Advisory Committee must recommend to the Hospital Licensee:

(a) whether an Applicant should be granted accreditation as an Accredited Practitioner; and

(b) the Scope of Clinical Practice for which an Applicant should be accredited.

10.2.7 The recommendation of the Medical Advisory Committee may include any recommended Special Conditions. Without limiting the generality of the foregoing, Special Conditions may include a requirement that newly qualified Accredited Practitioners participate in a formal mentoring and/or supervision program and comply with any requirements with respect to minimum procedural throughput (e.g. a requirement to demonstrate performance of a designated number of procedures within a designated period).

10.2.8 The Hospital Licensee must make a final determination regarding the application.

10.2.9 The Chief Executive Officer must notify the Applicant in writing of the Hospital Licensee's determination. If the Applicant is granted accreditation, the notice must set out:

(a) the term of the Accredited Practitioner's accreditation;

(b) the Accredited Practitioner's Scope of Clinical Practice; and

(c) any Special Conditions.

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11. Temporary Accreditation

11.1 A person seeking temporary accreditation must submit a Medical Application Form to the Chief Executive Officer of a Hospital in accordance with By-law 10.2.1.

11.2 Subject to the terms of the Chief Executive Officer's delegated authority, the Chief Executive Officer may approve temporary accreditation as an Accredited Practitioner (having first consulted with the chairperson of the relevant Medical Advisory Committee) and must determine the Scope of Clinical Practice applicable to the temporary accreditation.

11.3 Temporary accreditation granted under this By-law will remain in force until the earlier of:

11.3.1 if the temporarily accredited Accredited Practitioner has also applied for accreditation for a term, until the Hospital Licensee determines that application;

11.3.2 the expiry of a period of 3 months; and

11.3.3 if a Chief Executive Officer has specified a period of temporary accreditation shorter than 3 months, the expiry of that shorter period.

11.4 If an applicant is granted temporary accreditation, the Chief Executive Officer must issue a notice to the applicant which must set out:

11.4.1 the term of the temporary accreditation;

11.4.2 the Accredited Practitioner's Scope of Clinical Practice; and

11.4.3 any Special Conditions.

11.5 The Chief Executive Officer must notify the grant of temporary accreditation to the relevant Medical Advisory Committee.

11.6 Subject to the terms of the Chief Executive Officer's delegated authority, the Chief Executive Officer may (having first consulted with the chairperson of the relevant Medical Advisory Committee) extend temporary accreditation for a further period of no greater than three months.

11.7 Temporary accreditation under this By-law 11 is subject to disallowance by the Hospital Licensee (including disallowance on the advice of the relevant Medical Advisory Committee). Disallowance will not be treated as termination of accreditation for the purpose of By-law 17.

11.8 Temporary accreditation under this By-law 11 is at will and may be terminated by the Chief Executive Officer without cause at any time. Termination of temporary accreditation will not be treated as termination of accreditation for the purpose of By-law 17.

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12. Renewal of Accreditation

12.1 Accredited Practitioners

12.1.1 Not less than 60 days prior to the date on which an Accredited Practitioner's accreditation is due to expire, the Chief Executive Officer of the Hospital must notify the Accredited Practitioner of the pending expiry of their accreditation.

12.1.2 An Accredited Practitioner who wishes to renew their accreditation must apply for renewal in sufficient time before the expiry of their current accreditation to enable proper consideration of the application for renewal.

12.1.3 The processes for renewal of accreditation will be the same as for initial accreditation as set out in By-law 10.2, except that a Chief Executive Officer may (on advice from the relevant Medical Advisory Committee) waive or modify a generally applicable requirement to submit documentation or information where the submission of documentation or information would be unnecessary (for example, documentation or information which the Hospital Licensee has on file).

12.2 Lapsing of accreditation

If an Accredited Practitioner does not apply for renewal of his or her accreditation prior to the date on which it expires, the Accredited Practitioner's accreditation will lapse on that date.

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13. Voluntarily relinquishing accreditation

13.1 Subject to By-law 13.3, an Accredited Practitioner may voluntarily relinquish his or her accreditation by written notice to the Chief Executive Officer of the Hospital. An Accredited Practitioner's accreditation will expire on the date the notice is received or such later date specified in the notice.

13.2 On voluntarily relinquishing accreditation, an Accredited Practitioner must comply with the reasonable requirements of the Hospital Licensee with respect to the discharge of admitted patients and/or transfer of care of admitted patients to another Accredited Practitioner.

13.3 Unless otherwise determined by the Hospital Licensee, an Accredited Practitioner will not be permitted to voluntarily relinquish his or her accreditation:

13.3.1 if a review of the Accredited Practitioner's accreditation or Scope of Clinical Practice has been initiated under By-law 15 or a review is imminent; or

13.3.2 if the Accredited Practitioner's accreditation is suspended under By-law 16 or suspension is imminent.

14. Amendment of Scope of Clinical Practice

14.1 An Accredited Practitioner may, at any time, make an application for amendment of his/her Scope of Clinical Practice.

14.2 The Chief Executive Officer of a Hospital must cause any such application to be forwarded to the Medical Advisory Committee of the Hospital.

14.3 The processes for amendment of an Accredited Practitioner's Scope of Clinical Practice will be the same as for an application for initial accreditation as set out in By-law 10, except that the Chief Executive Officer may (on advice from the Medical Advisory Committee) waive or modify a generally applicable requirement to submit documentation or information where the submission of documentation or information would be unnecessary (for example, documentation or information which the Hospital Licensee has on file).

14.4 The Chief Executive Officer must notify the Applicant in writing of the Hospital Licensee's determination in relation to the requested amendment. The notice must set out the Accredited Practitioner's amended Scope of Clinical Practice and any Special Conditions determined to apply to the Accredited Practitioner's amended Scope of Clinical Practice.

15. Review of Scope of Clinical Practice

15.1 Internal Review

15.1.1 The Chief Executive Officer of a Hospital or the Hospital Licensee may, at any time, direct the Medical Advisory Committee to review an Accredited Practitioner's Scope of Clinical Practice. A review may be initiated:

(a) in connection with an issue, concern, complaint or allegation in respect of the Accredited Practitioner; or

(b) on a routine basis (for example, in response to changes in the capability of the Hospital to support the Accredited Practitioner's Scope of Clinical Practice).

15.1.2 Suspension of an Accredited Practitioner's accreditation under By-law 16 is not a prerequisite to initiation of a review under By-law 15.1.1.

15.1.3 The Accredited Practitioner must provide the Medical Advisory Committee with such documentation and information (and must otherwise cooperate with that Medical Advisory Committee) as required by that Medical Advisory Committee to review the Accredited Practitioner's Scope of Clinical Practice.

15.1.4 A Medical Advisory Committee:

(a) at any time during a review, may make a recommendation to the Hospital Licensee that the Accredited Practitioner's accreditation be suspended under By-law 16 pending completion of the review; and

(b) at completion of the review, must make a recommendation to the Hospital Licensee concerning:

(i) the continuation, suspension or termination of the Accredited Practitioner's accreditation;

(ii) the amendment of the Accredited Practitioner's Scope of Clinical Practice; and/or

(iii) the imposition of any Special Conditions on the Accredited Practitioner's accreditation.

15.1.5 The Hospital Licensee must make a final determination in relation to the matter having regard to the recommendation of the Medical Advisory Committee.

15.1.6 The Chief Executive Officer must notify the Accredited Practitioner in writing of the Hospital Licensee's determination in relation to the review initiated. Where applicable, the notice must set out the Accredited Practitioner's amended Scope of Clinical Practice and any Special Conditions applied to the Accredited Practitioner's amended Scope of Clinical Practice.

15.2 External (Independent) Review

15.2.1 The Chief Executive Officer of a Hospital or the Hospital Licensee may, at any time, appoint a competent person (**Independent Reviewer**) to review an Accredited Practitioner's Scope of Clinical Practice. A review may be initiated:

(a) in connection with an issue, concern, complaint or allegation in respect of the Accredited Practitioner; or

(b) on a routine basis (for example, in response to changes in the capability of a Hospital to support the Accredited Practitioner's Scope of Clinical Practice).

15.2.2 The Chief Executive Officer must inform the chairperson of the Medical Advisory Committee of the appointment of an Independent Reviewer under By-law 15.2.1.

15.2.3 Suspension of an Accredited Practitioner's accreditation under By-law 16 is not a prerequisite to initiation of a review under By-law 15.2.1.

15.2.4 The Accredited Practitioner must provide the Independent Reviewer with such documentation and information (and must otherwise cooperate with the Independent Reviewer) as required by the Independent Reviewer to review the Accredited Practitioner's Scope of Clinical Practice.

15.2.5 The Independent Reviewer:

(a) at any time during the review, may make a recommendation to the Hospital Licensee that the Accredited Practitioner's accreditation be suspended under By-law 16 pending completion of the review; and

(b) at completion of the review, must make a recommendation to the Hospital Licensee concerning:

(i) the continuation, suspension or termination of the Accredited Practitioner's accreditation;

(ii) the amendment of the Accredited Practitioner's Scope of Clinical Practice; and/or

(iii) the imposition of any Special Conditions on the Accredited Practitioner's accreditation.

15.2.6 The Chief Executive Officer must inform the chairperson of the Medical Advisory Committee of the recommendations of the Independent Reviewer under By-law 15.2.5.

15.2.7 The Hospital Licensee must make a final determination in relation to the matter.

15.2.8 The Chief Executive Officer of the Hospital must notify the Accredited Practitioner in writing of the Hospital Licensee's determination in relation to the review initiated. Where applicable, the notice must set out the Accredited Practitioner's amended Scope of Clinical Practice and any Special Conditions applied to the Accredited Practitioner's amended Scope of Clinical Practice.

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16. Suspension of accreditation

16.1 Power to suspend

16.1.1 The Chief Executive Officer of a Hospital must suspend the accreditation of an Accredited Practitioner if required by the Hospital Licensee and may, following consultation with the chairperson of the Medical Advisory Committee, suspend the accreditation of an Accredited Practitioner if the Chief Executive Officer considers:

(a) (**care or safety**) suspension of accreditation is in the interests of patient care or safety;

(b) (**unresolved allegations**) serious and unresolved allegations, complaints or concerns have been made in relation to the Accredited Practitioner;

(c) (**non-compliance**) the Accredited Practitioner is in breach of these By-laws or has failed to observe any General Conditions or Special Conditions of accreditation;

(d) (**Relevant Events**) the Accredited Practitioner has disclosed, is required to disclose, or may be required to disclose a Relevant Event to the National Board;

(e) (**impairment**) the Accredited Practitioner has, or may have, an impairment which is or may be inconsistent with continuing accreditation;

(f) (**disruptive conduct**) the conduct of the Accredited Practitioner is such that it is unduly hindering the efficient operation of the Hospital at any time;

(g) (**disreputable conduct**) the conduct of the Accredited Practitioner is bringing, or may bring the Hospital into disrepute.

16.2 Grounds of suspension separate and independent

Each ground for suspension specified in By-law 16.1 is separate and independent and is not limited by reference to any other ground specified in By-law 16.1.

16.3 Notice of suspension

The Chief Executive Officer must notify the Accredited Practitioner without delay of:

16.3.1 the decision to suspend the accreditation of the Accredited Practitioner;

16.3.2 if the suspension is expressed to continue until a particular event or occurrence (such as the Accredited Practitioner performing a specified action or satisfying a particular requirement), the relevant event or occurrence.

16.4 Termination and reinstatement

16.4.1 Suspension of accreditation ends:

(a) on termination of the Accredited Practitioner's accreditation under By-law 17; or

(b) on receipt by the Accredited Practitioner of notice from the Chief Executive Officer of the Hospital that accreditation has been reinstated.

16.4.2 The Chief Executive Officer may, following consultation with the chairperson of the Medical Advisory Committee, reinstate the suspended accreditation of an Accredited Practitioner. The reinstatement may be unconditional or subject to such Special Conditions as determined by that Chief Executive Officer and specified in the notice of reinstatement.

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17. Termination of accreditation

17.1 Basis of termination

A Hospital Licensee may terminate an Accredited Practitioner's accreditation at the Hospital if:

17.1.1 (**registration actions**) the Accredited Practitioner's registration as a Health Practitioner under the Health Practitioner Regulation National Law:

(a) is suspended or cancelled;

(b) is made subject to a condition inconsistent with continued accreditation;

17.1.2 (**impairment**) the Accredited Practitioner has an impairment that is, in the reasonable opinion of the Hospital Licensee, inconsistent with continuing accreditation;

17.1.3 (**adverse finding**) an Adjudication Body makes an adverse finding, whether formal or informal, in relation an Accredited Practitioner (including a caution or reprimand) which is, in the reasonable opinion of the Hospital Licensee, inconsistent with continued accreditation;

17.1.4 (**adverse finding – overseas jurisdictions**) an event analogous to an event in By-law 17.1.3 occurs in any jurisdiction other than Australia which is, in the reasonable opinion of the Hospital Licensee, inconsistent with continued accreditation;

17.1.5 (**insurance**) the Accredited Practitioner ceases to hold insurance as required by the General Conditions of accreditation;

17.1.6 (**compliance with By-laws**) the Accredited Practitioner is in breach of these By-laws or has failed to observe any General Conditions or Special Conditions of accreditation;

17.1.7 (**disruptive conduct**) the conduct of the Accredited Practitioner is such that it is unduly hindering the efficient operation of a Hospital at any time;

17.1.8 (**disreputable conduct**) conduct of the Accredited Practitioner is bringing, or may bring a Hospital into disrepute;

17.1.9 (**permanent incapacity**) the Accredited Practitioner has been incapable of performing his/her duties as an Accredited Practitioner at the Hospital for a period of 6 months or greater;

17.1.10 (**results of review**) a review of the Accredited Practitioner's Scope of Clinical Practice has been initiated under By-law 15 and a Medical Advisory Committee or the Independent Reviewer (as applicable) recommends termination of Accreditation;

17.1.11 (**criminal offences**) the Accredited Practitioner:

(a) is charged, whether in Australia or elsewhere, with an offence punishable by 12 months imprisonment or more; or

(b) is convicted of or the subject of a finding of guilt for an offence, whether in Australia or elsewhere, punishable by imprisonment;

17.1.12 (**Relevant Event**) a Relevant Event has occurred in relation to the Accredited Practitioner and, in the reasonable opinion of the Hospital Licensee, the Relevant Event warrants termination of accreditation;

17.1.13 (**employment**) where the Accredited Practitioner is an employee of a Hospital, the Accredited Practitioner ceases to be an employee;

17.1.14 (**inability to support Scope of Clinical Practice**) the Hospital has ceased to be capable of supporting the Accredited Practitioner's Scope of Clinical Practice.

17.2 Grounds of termination separate and independent

Each ground for termination specified in By-law 17.1 is separate and independent and is not limited by reference to any other ground specified in By-law 17.1.

17.3 Termination without cause

Termination of accreditation on the grounds specified in By-laws 17.1.13 and 17.1.14 is not considered termination for cause and is not appealable under By-law 19.

17.4 Notice of termination

The Chief Executive Officer of a Hospital must notify the Accredited Practitioner without delay of the decision to terminate accreditation.

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18. Notification to other bodies

The Chief Executive Officer of a Hospital or the Hospital Licensee may, where permitted by law:

18.1.1 make a notification under the Health Practitioner Regulation National Law in relation to any fact, matter or circumstance, or alleged matter or circumstance, concerning an Accredited Practitioner (including any fact, matter or circumstance which may be grounds for the suspension or termination of accreditation or the imposition of a Special Condition of accreditation); or

18.1.2 notify any other hospital or health facility of the suspension or termination of accreditation of an Accredited Practitioner, or the variation of an Accredited Practitioner's Scope of Clinical Practice, under these By-laws.

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19. Appeal

19.1 Appealable Decisions

19.1.1 The following decisions are appealable by an Accredited Practitioner (each a **Appealable Decision**):

(a) the Hospital Licensee declines to renew an Accredited Practitioner's accreditation on application under By-law 12;

(b) the Hospital Licensee amends an Accredited Practitioner's Scope of Clinical Practice or imposes a material Special Condition under By-law 15 (except where the Special Condition is imposed by agreement with the Accredited Practitioner);

(c) the Chief Executive Officer suspends an Accredited Practitioner's accreditation under By-law 16;

(d) the Chief Executive Officer imposes a material Special Condition on reinstating an Accredited Practitioner's accreditation under By-law 16 (except where the Special Condition is imposed by agreement with the Accredited Practitioner); and

(e) the Hospital Licensee terminates an Accredited Practitioner's accreditation under By-law 17.

19.1.2 Except as provided in By-law 19.1.1, an Accredited Practitioner has no right of appeal in relation to any decision or determination made pursuant to these By-laws.

19.2 Lodgement of appeals

19.2.1 If an Accredited Practitioner wishes to appeal an Appealable Decision, the Accredited Practitioner must lodge an appeal in writing with the Chief Executive Officer within 14 days from the date of notification of the relevant decision.

19.2.2 If an appeal is not lodged within the time required by this By-law 19, any right of appeal will lapse.

19.2.3 The Chief Executive Officer of a Hospital must refer an appeal duly lodged in accordance with this By-law 19 to the Hospital Licensee.

19.3 Appeal Committee

The Hospital Licensee must convene a committee (**Appeal Committee**) to hear the appeal. The Appeal Committee must comprise:

(a) a nominee of the Hospital Licensee;

(b) a nominee of the Medical Advisory Committee; and

(c) a nominee of the relevant professional college of the appellant.

19.4 Chairperson

The chairperson of the Appeal Committee will be the nominee of the Hospital Licensee.

19.5 Reasons Statement

19.5.1 On the convening of an Appeal Committee in relation to a decision, the Chief Executive Officer must provide to the appellant a document (a **Reasons Statement**) setting out:

(a) the basis of, and reasons for, the decision; and

(b) particulars of any facts and circumstances on which the decision was based.

19.5.2 Where the basis of, and reasons for, the decision which is the subject of the appeal is apparent from the notice of the decision, the Chief Executive Officer may determine that the notice itself will be taken to be the Reasons Statement.

19.5.3 Where the decision which is the subject of the appeal was substantially based on a recommendation of the Medical Advisory Committee, the chairperson of the Medical Advisory Committee must provide such documentation, information and assistance necessary to enable the Chief Executive Officer to prepare the Reasons Statement.

19.5.4 The Appeal Committee must provide the appellant with sufficient opportunity to consider the Reasons Statement and make submissions to the Appeal Committee in relation to the decision.

19.6 Submissions

19.6.1 The appellant must provide written submissions to the Appeal Committee in relation to the decision which is the subject of the appeal.

19.6.2 The Appeal Committee may, in its absolute discretion, invite the appellant to make oral submissions to the Appeal Committee. If the Appeal Committee invites the appellant to make oral submissions, the appellant is not entitled to have legal representation present.

19.7 Procedure

The chairperson of the Appeal Committee must determine any question of procedure for the Appeal Committee.

19.8 Determination of the appeal

19.8.1 The Appeal Committee must determine the appeal by deciding whether the decision which was the subject of the appeal was the correct and preferable decision, having regard to the material before the Appeal Committee, including the Reasons Statement and any submissions of the appellant.

19.8.2 The Appeal Committee must determine the appeal by recommending that the Hospital Licensee:

(a) affirm the decision which was the subject of the appeal;

(b) vary the decision which was the subject of the appeal;

(c) reconsider the decision which was the subject of the appeal,

in each case having regard to the reasons and observations of the Appeal Committee.

19.9 Recommendation and determination

The Appeal Committee's determination must be provided to the Hospital Licensee in the form of a written recommendation. The Hospital Licensee must consider the recommendation and make a final determination in relation to the decision which is the subject of the appeal. The final determination of the Hospital Licensee is binding.

19.10 Notification of determination

The Chief Executive Officer must notify the appellant of the Hospital Licensee's final determination in writing within 14 days.

Part D Medical Advisory Committee

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20. Medical Advisory Committee

20.1 Appoint of the Medical Advisory Committee

Each Hospital Licensee must appoint and maintain a Medical Advisory Committee for the Hospital in accordance with the Licensing Act and these By-laws.

20.2 Role

The Medical Advisory Committee of a Hospital is advisory to the Chief Executive Officer and the Hospital Licensee and must:

20.2.1 advise in relation to accreditation of Accredited Practitioners and defining their Scope of Clinical Practice in accordance with these By-laws;

20.2.2 advise on matters concerning clinical practice at the Hospital;

20.2.3 advise on matters concerning patient care and safety at the Hospital; and

20.2.4 advise on any other matter required by the Licensing Act or by law.

Without limiting the foregoing, the Medical Advisory Committee must:

20.2.5 facilitate communication between the Hospital and the Accredited Practitioners;

20.2.6 represent the collective views of the Accredited Practitioners (to the extent it is possible to do so);

20.2.7 provide a means whereby Accredited Practitioners can participate in the policy making and planning processes of the Hospital;

20.2.8 assist in identifying health needs of the community and the services which may be required to meet these needs;

20.2.9 participate in the planning, development and implementation of quality programs of the Hospital;

20.2.10 ensure that a formal mechanism for review of clinical outcomes and management is established and perform such a function in accordance with the requirements of these By-laws; and

20.2.11 advise the Chief Executive Officer and the Hospital Licensee in relation to such other matters and provide such other assistance to the Chief Executive Officer and the Hospital Licensee as may be reasonably required.

20.3 Membership

20.3.1 The Medical Advisory Committee must comprise:

(a) at least five Accredited Practitioners;

(b) the Chief Executive Officer;

(c) the Director of Nursing (who shall attend meetings in a non-voting, advisory capacity);

(d) such other persons determined by the Hospital Licensee; and

(e) those persons required by the Licensing Act and such other persons determined by the Hospital Licensee.[4]

20.3.2 The Chief Executive Officer and the Director of Nursing are not eligible to be officeholders of the Medical Advisory Committee.

20.4 Term

The Accredited Practitioner members of the Medical Advisory Committee will be appointed for the term of their accreditation.

20.5 Vacancies

The Hospital Licensee may appoint an Accredited Practitioner to fill any casual vacancy on the Medical Advisory Committee and the Accredited Practitioner so appointed will hold office for the remainder of the term of the vacated member. The vacancy must be filled by an Accredited Practitioner from the same clinical specialty as the vacated member.

20.6 Sub-committees

20.6.1 The Medical Advisory Committee of a Hospital may, with the approval of the Chief Executive Officer, form sub-committees to assist in carrying out its functions.

20.6.2 The role and functions of a sub-committee must be set out in written terms of reference determined by the Medical Advisory Committee and approved by the Chief Executive Officer.

20.6.3 A sub-committee may be advisory to the Medical Advisory Committee or exercise a delegated authority or function of the Medical Advisory Committee.

20.7 Power to co-opt

A Medical Advisory Committee (including any sub-committees thereof) may co-opt the services of any other person should it consider this necessary. That person or persons will not have voting rights at any meeting of the Medical Advisory Committee or any sub-committee.

20.8 Resignation from the Medical Advisory Committee

A member of a Medical Advisory Committee may resign from his or her membership by giving at least 1 month's notice in writing to the Chief Executive Officer of the Hospital.

20.9 Meetings

20.9.1 Ordinary meetings of a Medical Advisory Committee must be held not less than 4 times a year at a time and place to be determined by the chairperson in consultation with the Chief Executive Officer of the Hospital. 7 days' notice must be given by the chairperson (or delegate) of every ordinary meeting of a Medical Advisory Committee.

20.9.2 A special meeting of a Medical Advisory Committee may be called by the chairperson of the Medical Advisory Committee, subject to the approval of the Chief Executive Officer (which must not be unreasonably withheld).

20.9.3 Subject to By-law 20.9.4, at least 7 days' notice of a special meeting must be given by the chairperson of a Medical Advisory Committee (or delegate) to each member of the Medical Advisory Committee entitled to attend such a meeting. Notice of a special meeting must specify the business to be considered and no other business may be considered, except by unanimous approval of each member of the Medical Advisory Committee.

20.9.4 In an emergency, the chairperson of a Medical Advisory Committee (or delegate) must give as much notice as is practicable in the context of the emergency to each member of the Medical Advisory Committee entitled to attend such a meeting.

20.9.5 The quorum for a meeting of a Medical Advisory Committee will be five members of the Medical Advisory Committee.

20.9.6 The chairperson of a Medical Advisory Committee must determine any question of procedure for the Medical Advisory Committee.

20.10 Emergencies

If:

20.10.1 a decision of a Medical Advisory Committee is required in an emergency; and

20.10.2 it is not practicable to convene a meeting of the Medical Advisory Committee in the context of the emergency,

the Chief Executive Officer in consultation with the chairperson of the Medical Advisory Committee will be empowered to act on behalf of the committee (subject to later ratification by the Medical Advisory Committee).

20.11 Chairperson

A chairperson of a Medical Advisory Committee must be elected for an annual term from the Accredited Practitioner members of the Committee.

20.12 Deputy Chairperson

20.12.1 A deputy chairperson of a Medical Advisory Committee must be elected for an annual term from the Accredited Practitioner members of the Committee.

20.12.2 A role or function conferred on the chairperson of a Medical Advisory Committee under these By-laws may be performed by the deputy chairperson if the chairperson is unavailable (or, in an emergency, is unable to be contacted promptly).

20.12.3 If the chairperson is not present at any meeting of a Medical Advisory Committee, the deputy chairperson may act as the chairperson of the meeting.

20.12.4 In the absence of both the chairperson and the deputy chairperson of a Medical Advisory Committee, the Accredited Practitioner members of the Medical Advisory Committee may elect one of their number to be the chairperson of the meeting.

20.13 Procedure

20.13.1 The Accredited Practitioner members of a Medical Advisory Committee and the Chief Executive Officer are entitled to vote at meetings of the Medical Advisory Committee.

20.13.2 All questions, except as otherwise provided in these By-laws, must be decided by a show of hands, or where demanded by a member entitled to vote, a ballot. In the case of an equality of votes, the chairperson of the meeting may exercise, but is not required to exercise, a casting vote.

20.13.3 A member of a Medical Advisory Committee may, in the event of his or her absence from a meeting of the Medical Advisory Committee, appoint an Accredited Practitioner as a proxy. The proxy so appointed is entitled to attend and be heard at the meeting on behalf of, and exercise the voting rights of, his or her appointer.

20.14 Minutes

20.14.1 Minutes of all meetings of a Medical Advisory Committee must be prepared by the relevant Chief Executive Officer (or delegate).

20.14.2 Minutes of a Medical Advisory Committee must be distributed to all those entitled to attend meetings of the Medical Advisory Committee prior to the next meeting.

20.14.3 Except for an emergency meeting of a Medical Advisory Committee, no business may be considered at a meeting of the Medical Advisory Committee until the minutes of the previous meeting have been confirmed or otherwise disposed of. No discussion of the minutes is permitted except as to their accuracy.

20.14.4 Minutes of a meeting of a Medical Advisory Committee must be confirmed by resolution of the Medical Advisory Committee and signed by the chairperson at the next meeting. Minutes so confirmed and signed shall be taken as evidence of the proceedings of the relevant meeting.

20.15 No representation

A member of a Medical Advisory Committee does not represent, and must not purport to represent in any way, the Hospital Licensee or Unitas Healthcare except with the prior, express written permission of the Hospital Licensee or the Chief Executive Officer of Unitas Healthcare (respectively). Without limiting the foregoing, letterhead of the Hospital may only be used for official purposes and not for any other purpose.

Part E Research and New Clinical Procedures

21. Research

21.1 An Accredited Practitioner must not undertake medical research at a Hospital, or involving any patient of a Hospital, unless:

21.1.1 the medical research is within the Scope of Clinical Practice of each Accredited Practitioner involved in the research;

21.1.2 if the medical research may raise ethical issues or involves human subjects, the Accredited Practitioner has submitted details of the research for review, and the research has been approved by, a Human Research Ethics Committee;

21.1.3 the Accredited Practitioner has notified (in any form prescribed by the Chief Executive Officer):

(a) the Chief Executive Officer; and

(b) the Medical Advisory Committee;

21.1.4 the Chief Executive Officer is satisfied that appropriate insurance cover is in place in relation to the research; and

21.1.5 the Chief Executive Officer has approved the commencement of the medical research in writing.

21.2 The authority of a Chief Executive Officer to approve medical research at a Hospital is subject to the terms of the Chief Executive Officer's authority delegated by the Hospital Licensee.

21.3 The Chief Executive Officer of a Hospital may refer any proposal to undertake medical research at that Hospital, or involving any patient of that Hospital, to the Medical Advisory Committee for additional review and advice.

21.4 Medical research must be conducted in accordance with the requirements of the Human Research Ethics Committee approval applicable to the research.

22. New Clinical Procedures

22.1 In this By-law:

New Clinical Procedure means a clinical service, procedure or other intervention being introduced into a Hospital for the first time. A New Clinical Procedure may be, but will not necessarily be, experimental.

22.2 An Accredited Practitioner who proposes to introduce a New Clinical Procedure at a Hospital must apply to the Chief Executive Officer in writing and provide such information as may be requested by the Chief Executive Officer in relation to the New Clinical Procedure. The Chief Executive Officer may refer the proposal to the Medical Advisory Committee who must advise the Chief Executive Officer with respect to:

22.2.1 the introduction of the New Clinical Procedure in the Hospital; and

22.2.2 whether the New Clinical Procedure is within the Accredited Practitioner's approved Scope of Clinical Practice.

22.3 An Accredited Practitioner must not undertake a New Clinical Procedure at a Hospital, or involving any patient of a Hospital, unless:

22.3.1 the New Clinical Procedure is within the Accredited Practitioner's approved Scope of Clinical Practice;

22.3.2 the Chief Executive Officer of the Hospital is satisfied that appropriate insurance cover is in place for the New Clinical Procedure; and

22.3.3 the Chief Executive Officer has approved the introduction of the New Clinical Procedure in writing.

22.4 For the avoidance of doubt, a Chief Executive Officer is entitled to consider the financial and operational implications of a New Clinical Procedure for a Hospital.

22.5 If the New Clinical Procedure is experimental, or may raise ethical issues or involves human subjects, the Accredited Practitioner must comply with By-law 21.

Part F General Provisions

23. Conflicts of Interest

23.1 In this By-law:

conflict of interest means the existence of any fact or circumstance which would, or would be perceived to, cause the person to be unable to discharge his or her obligations in an objective and independent manner to the best of his or her ability.

23.2 A member of any committee or group established for a Hospital under these By-laws, or a person authorised to attend any meeting of such a committee or group, who has a direct or indirect pecuniary interest, a conflict of interest or a potential conflict of interest:

23.2.1 in a matter that has been considered or is about to be considered at a meeting of a committee or group;

23.2.2 in a thing done or proposed to be done by the Hospital,

must:

23.2.3 as soon as possible, notify the other members of the committee or group of the interest and the nature of the interest; and

23.2.4 not participate in the discussion of the matter or thing (except, having disclosed the interest, by invitation of the Chief Executive Officer).

23.3 In the circumstances in By-law 23.2, the person is not eligible to exercise any function conferred upon an officeholder of the committee or group in relation to the relevant matter or thing.

23.4 A disclosure by a person to the committee or group that the person:

23.4.1 is a shareholder, partner, employee or contractor of a specified company, person or body; or

23.4.2 has some other specified interest relating to a specified company, person or body,

may be given as a standing notice. A standing notice is taken to be sufficient disclosure of the nature of the interest in any matter or thing relating to the specified company, person or body which may arise after the date of the standing notice.

23.5 The chairperson of the committee or group must cause particulars of any disclosure made under By-laws 23.2 or 23.4 to be recorded in the minutes of the committee.

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24. Confidentiality

24.1 Obligation of confidentiality

24.1.1 The processes governing the accreditation of Accredited Practitioners under these By-laws and the proceedings of each committee or group established under these By-laws are confidential information (**Confidential Information**).

24.1.2 An person must not:

(a) use or disclose Confidential Information; or

(b) make or retain a copy of Confidential Information (in any form or medium),

other than for the purpose of discharging any obligation or function conferred upon the person under these By-laws.

24.2 Exceptions to obligations of confidentiality

By-law 24.1 does not apply where:

24.2.1 the relevant information is already in the public domain (except because of a breach of these By-laws);

24.2.2 disclosure of the relevant information is required to comply with applicable law; or

24.2.3 disclosure of the relevant information is required by, or contemplated by, these By-laws (for example, a notification under By-law 18).

24.3 Specific confidentiality undertakings

A Hospital Licensee may require an Accredited Practitioner, or any other person, to sign a binding confidentiality undertaking giving effect to, or supplementing, this By-law 24.

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25. No Compensation

A member of a committee or group established under these By-laws is not entitled to receive compensation for any services rendered in that capacity.

26. Statutory Immunity

A Medical Advisory Committee or other committee or group established under these By-laws may, with the consent of the Hospital Licensee, seek approval for statutory immunity (or equivalent) under applicable legislation governing quality assurance activities. Should a Medical Advisory Committee or any committee or group be approved under applicable legislation, each such committee or group must operate in accordance with the requirements of the applicable legislation.

27. General Procedural Rules

27.1 Delegation

27.1.1 Where an administrative function, such as the preparation of minutes, is conferred on a Chief Executive Officer under these By-laws, that administrative function may be satisfied by a Chief Executive Officer causing a delegate to perform that administrative function on behalf of that Chief Executive Officer.

27.1.2 By-law 27.1.1 does not authorise a Chief Executive Officer to delegate a decision making power or function under these By-laws (including the decision making powers and functions in relation to accreditation of Accredited Practitioners conferred on the Chief Executive Officer under these By-laws).

27.1.3 Where a decision making power or function is conferred on the Hospital Licensee under these By-laws, where permitted by law, the power or function may be delegated to a suitable qualified person or committee of persons. A committee may, with the approval of the Hospital Licensee, co-opt the services of any other person as it sees fit.

27.2 Quorum

Except where provided otherwise in these By-laws, where a reference is made to a meeting of a committee or group, the following quorum requirements apply:

27.2.1 where there is an odd number of members of the committee or group, a majority of the members; or

27.2.2 where there is an even number of members of the committee or group, one half of the number of the members plus one,

or as otherwise provided by the Hospital Licensee.

27.3 Resolutions without meetings

A decision may be made by a committee or group established pursuant to these By-laws (except the Appeal Committee established by By-law 19) without a meeting if each member of the committee or group sign a document stating they are in favour of the decision. A facsimile or electronic message containing the text of the relevant document recording the decision, expressed to have been approved by a committee or group member, is taken to be a document signed by the relevant committee or group member.

27.4 Meeting by electronic means

A committee or group established pursuant to these By-laws may hold any meeting by electronic means whereby participants can be heard and can hear but are not necessarily in

the same place. The requirements of these By-laws shall nonetheless apply to such a meeting.

27.5 Voting

Unless otherwise specified in these By-laws, voting shall be on a simple majority basis and only by those in attendance at the meeting of the relevant committee or group and there will be no proxy vote.

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28. Disputes

Any dispute or difference relating to:

28.1.1 the powers of any committee or group established pursuant to these By-laws;

28.1.2 the validity of the proceedings of any such committee or group; or

28.1.3 the procedures for accreditation, credentialing and defining of the Scope of Clinical Practice of Accredited Practitioners under these By-laws,

will be determined by the Hospital Licensee. Subject to any rights of an Accredited Practitioner under By-law 19, the Hospital Licensee's determination in relation to the dispute or difference will be final.

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29. Rules and policies

A Hospital Licensee may make rules and policies applicable to Accredited Practitioners in relation to the Hospital not inconsistent with these By-laws.

Attachment 1 General Conditions

1. Compliance with General Conditions and Special Conditions

An Accredited Practitioner must comply with the General Conditions of accreditation (set out in this Attachment 1) and any Special Conditions of accreditation.

2. Compliance and Conduct

2.1 An Accredited Practitioner must comply with:

2.1.1 these By-laws;

2.1.2 all applicable laws, including laws governing the registration and conduct of health practitioners, private health facilities and the provision of Medicare-eligible professional services;

2.1.3 the rules, policies and procedures of the Hospital including in relation to:

(a) workplace health and safety;

(b) anti-discrimination, harassment and bullying;

(c) patient consent;

(d) health records and information privacy;

(e) medication management; and

(f) informed financial consent; and

2.1.4 generally accepted professional and ethical standards applicable to the Accredited Practitioner's profession and specialty.[5]

2.2 An Accredited Practitioner must comply with the code of conduct applicable to the Hospital.

2.3 An Accredited Practitioner must comply with the reasonable and lawful requirements of the Hospital Licensee with respect to personal conduct in the Hospital.

2.4 An Accredited Practitioner must observe the general conditions and requirements of clinical practice in the Hospital (whether or not such conditions and requirements are recorded as formal rules, policies or procedures of the Hospital).

2.5 An Accredited Practitioner must not aid or facilitate the provision of medical or dental care by persons who are not Accredited Practitioners (including utilising surgical assistants who are not Accredited Practitioners). Without limiting the foregoing, an Accredited Practitioner must strictly comply with Hospital policy with respect to:

2.5.1 the presence of persons in clinical areas representing medical device and medical technology suppliers (including technicians); and

2.5.2 the presence of healthcare students in clinical areas.

[5] For the avoidance of doubt, and without limiting the generality of the condition in item 2.1.4, the Hospital Licensee considers the raising of fees by an Accredited Practitioner which are, in all the circumstances, manifestly excessive to be contrary to generally accepted professional and ethical standards.

3. Insurance

3.1 An Accredited Practitioner must take out and maintain professional indemnity insurance:

3.1.1 in accordance with the registration standards determined under the Health Practitioner Regulation National Law;

3.1.2 which satisfies any other requirement of the Hospital Licensee and/or Unitas Healthcare Group Policy (including limits of indemnity);

3.1.3 which must indemnify the Accredited Practitioner in respect of the entirety of his or her Scope of Clinical Practice; and

3.1.4 which does not have material exclusions, excesses or deductibles relevant to the Accredited Practitioner's Scope of Clinical Practice.

4. Quality Assurance and Continuing Professional Development

4.1 An Accredited Practitioner must:

4.1.1 participate in peer review, clinical review, clinical audit and quality assurance activities established by the Medical Advisory Committee;

4.1.2 participate in the collection, review and reporting of quality indicators for the Hospital;

4.1.3 assist the Hospital Licensee in relation to the maintenance of accreditation of the Hospital (including responding to requests for information from the Hospital and/or its accrediting agency).

4.2 An Accredited Practitioner must participate in continuing professional development:

4.2.1 in accordance with the registration standards determined under the Health Practitioner Regulation National Law;

4.2.2 in accordance with the mandatory requirements of his or her specialist college or professional body; and

4.2.3 as otherwise required by the Chief Executive Officer or Medical Advisory Committee.

5. Activity

5.1 An Accredited Practitioner must maintain a regular level of activity at the Hospital in which he or she is accredited.

5.2 For the purpose of item 5.1, a "regular level of activity" may be determined by the Chief Executive Officer. In the absence such a determination, a "regular level of activity" means:

5.2.1 for an anaesthetist or proceduralist, a regular and utilised operating list per month;

5.2.2 for a physician, or non-proceduralist, an average of at least one Hospital admission per month; or

5.2.3 for any other Accredited Practitioner, attending on or reporting in relation to a Hospital's patients on a regular basis each month; and

5.2.4 where relevant and applicable to the Accredited Practitioner's specialty or clinical service type, regular participation on a Hospital administered roster for the day-to-day delivery of care.

5.3 Activity will be measured over a period of 6 months, taking into account ordinary personal and recreational leave, continuous professional development, and civil and humanitarian service.

6. Continuous Disclosure

6.1 An Accredited Practitioner must annually, or otherwise on request, provide to the Chief Executive Officer, in accordance with the administrative practice applicable in the Hospital in which the Accredited Practitioner is accredited:

6.1.1 evidence of the Accredited Practitioner's registration as a Health Practitioner under the Health Practitioner Regulation National Law;

6.1.2 evidence that the Accredited Practitioner holds professional indemnity insurance satisfying the requirements of these By-laws;

6.1.3 evidence that the Accredited Practitioner has satisfied the requirements of these By-laws with respect to continuing professional development; and

6.1.4 a declaration in the form required by the Hospital Licensee regarding facts and circumstances relevant to the Accredited Practitioner's accreditation and/or Scope of Clinical Practice at the Hospital.

6.2 An Accredited Practitioner must, without delay, notify the Chief Executive Officer if:

6.2.1 (**registration actions**) the Accredited Practitioner's registration as a Health Practitioner under the Health Practitioner Regulation National Law:

(a) is suspended or cancelled;

(b) is made subject to a condition,

6.2.2 (**adverse finding**) an Adjudication Body makes an adverse finding, whether formal or informal, in relation the Accredited Practitioner (including a caution or reprimand);

6.2.3 (**adverse finding – overseas jurisdictions**) an event analogous to an event in item 6.2.2 occurs in any jurisdiction other than Australia;

6.2.4 (**investigation**) the Accredited Practitioner is the subject of an investigation or inquiry in respect of his or her practice by a regulatory, disciplinary or investigative agency or a professional body in any jurisdiction;

6.2.5 (**Relevant Event**) a **Relevant Event** has occurred in relation to the Accredited Practitioner;

6.2.6 (**impairment**) the Accredited Practitioner has an impairment;

6.2.7 (**professional indemnity insurance**) the Accredited Practitioner has ceased to hold professional indemnity insurance satisfying the requirements of these By-laws;

6.2.8 (**credentialing information**) the Accredited Practitioner becomes aware of any fact or circumstance that would cause any information or documentation provided

in an application for accreditation or re-accreditation under these By-laws to be incorrect, incomplete or otherwise misleading.

6.3 An Accredited Practitioner must, without delay, notify the Chief Executive Officer of any other fact or circumstance:

6.3.1 relevant to the Accredited Practitioner's accreditation and/or Scope of Clinical Practice at the Hospital; or

6.3.2 relevant to the Accredited Practitioner's professional duties and/or ability to deliver clinical services safely and effectively.

7. Cooperation with Investigations

7.1 An Accredited Practitioner must cooperate with any review, investigation, enquiry or process undertaken by or on behalf of the Hospital Licensee in relation to:

7.1.1 the Accredited Practitioner's accreditation or Scope of Clinical Practice at the Hospital;

7.1.2 the Accredited Practitioner's suitability to practice at the Hospital;

7.1.3 the behaviour or conduct of the Accredited Practitioner.

7.2 An Accredited Practitioner must cooperate with any lawful review, investigation, enquiry or process undertaken by or on behalf of the Hospital Licensee concerning another Accredited Practitioner or any other Health Practitioner or Hospital personnel.

8. Records

8.1 An Accredited Practitioner must maintain complete, accurate and legible medical records:

8.1.1 in a contemporaneous and timely fashion;

8.1.2 in the form used in the Hospital and complying with the medical records policy of that Hospital;

8.1.3 in accordance with legal requirements;

8.1.4 in accordance with the requirements of the accreditation agency for the Hospital; and

8.1.5 in a way which enables the Hospital to collect revenue in a timely fashion.

8.2 Without limiting the condition in item 8.1, an Accredited Practitioner must comply with the Hospital's lawful requirements with respect to:

8.2.1 documenting patient consent to treatment;

8.2.2 admission and discharge of patients;

8.2.3 written confirmation of verbal orders for treatment;

8.2.4 requests and orders for diagnostic tests; and

8.2.5 prescriptions and orders for drugs and therapeutic goods.

8.3 An Accredited Practitioner must provide all reasonable assistance to enable the maintenance of medical records in electronic form.

8.4 An Accredited Practitioner must only access medical records of a Hospital:

8.4.1 to facilitate the care and treatment of patients of that Hospital;

8.4.2 in accordance with Privacy Laws; and

8.4.3 in accordance with any applicable access controls.

9. Hospital Administration

9.1 An Accredited Practitioner must give adequate notice of any scheduled absence or intention to postpone or cancel a procedural list or session which has been booked for the Accredited Practitioner at a Hospital in accordance with the standard administrative practices of the Hospital.

9.2 An Accredited Practitioner must participate in on-call arrangements as reasonably required by the Hospital.

9.3 An Accredited Practitioner must ensure he or she is available for emergency call to the Accredited Practitioner's patients (or has deputised an appropriately qualified Accredited Practitioner for this purpose).

9.4 An Accredited Practitioner must not purport to represent in any way (including by use of letterhead), the Hospital Licensee or Unitas Healthcare except with the prior, express written permission of the Hospital Licensee or the Managing Director of Unitas Healthcare (respectively).

10. Teaching and Training

Where applicable to the Hospital an Accredited Practitioner must facilitate, promote and participate in the teaching and training of Hospital personnel, junior medical staff, clinical trainees and medical students

Attachment 2 Accreditation of Allied Health Practitioners

1. Accreditation of Allied Health Practitioners

1.1 Non-employee Allied Health Practitioners

1.1.1 An Allied Health Practitioner (other than an Allied Health Practitioner employed by a Hospital) is only permitted to be involved in the treatment of a patient at a Hospital if the Allied Health Practitioner is accredited under these By-laws at that Hospital.

1.1.2 Accreditation does not give the Allied Health Practitioner any right or entitlement to access a Hospital (or any facility in a Hospital).

1.2 Accreditation is subject to adequate insurance

An Allied Health Practitioner may only be accredited under these By-laws if the Chief Executive Officer of the Hospital is satisfied that the insurance cover held by the applicant is adequate.

1.3 Accreditation Process

1.3.1 An Allied Health Practitioner seeking accreditation at a Hospital (the **Applicant**) must complete an application form (**Allied Health Application**) and provide the form to the Chief Executive Officer of the Hospital.

1.3.2 The Chief Executive Officer of a Hospital may grant accreditation to an Allied Health Practitioner having reviewed a duly completed Allied Health Application, having regard to:

(a) the Applicant's qualifications, professional training, skills and experience;

(b) the Applicant's current status and history with respect to professional registration, disciplinary action and insurance; and

(c) the Applicant's character and good standing with his or her peers.

1.3.3 The Chief Executive Officer of a Hospital may, in his or her discretion, refer an Allied Health Application to the Hospital's Medical Advisory Committee for consideration and advice.

1.3.4 Having considered an Allied Health Application in accordance with item 1.3.3, the Medical Advisory Committee must recommend to the Chief Executive Officer:

(a) whether the Applicant should be granted accreditation at the Hospital; and

(b) any conditions which should applied to the Applicant.

1.3.5 If the Applicant is granted accreditation, the Chief Executive Officer must notify the applicant in writing setting out:

(a) the term of the accreditation; and

(b) any Special Conditions applicable to the accreditation.

1.4 **Term of accreditation**

A Chief Executive Officer may determine the term for which an Allied Health Practitioner is accredited under these By-laws.

1.5 **Accreditation as an Allied Health Practitioner is at will**

Accreditation as an Allied Health Practitioner is at will and may be terminated by the Chief Executive Officer of the Hospital without cause at any time.

1.6 **No right of appeal**

There is no right of appeal against a decision to terminate the accreditation of an Allied Health Practitioner.

1.7 **Terms and conditions of accreditation**

1.7.1 An accredited Allied Health Practitioner must comply with the requirements applicable to Accredited Practitioners as set out in these By-laws (including the General Conditions of accreditation set out in Attachment 1) to the fullest extent that such requirements are capable of being applied to Allied Health Practitioners.

1.7.2 Without limiting item 1.7.1, where these By-laws specify a requirement applicable to Accredited Practitioners which is capable of being applied to Allied Health Practitioners, a reference in that requirement to an Accredited Practitioner will be taken to be a reference to an Allied Health Practitioner.