FacilityBy -Laws

Ramsay Health Care Group

Endorsed by
Ramsay Health Care Board
18 March 2008

Version 2.0

Table of Contents

Foreword **3**

The By-Laws **4**
- What are these By-Laws? 4
- Authority to make and amend these By-Laws 4
- The purposes of these By-Laws 4
- Compliance with these By-Laws 4
- Reading and interpreting these By-Laws 4
- Quorum/meetings 10
- Voting 11
- Disputes 11

Chief Executive Officer **11**

Director of Clinical Services and Director of Medical Services **12**

Executive staff **12**

Executive Management Committee **13**

Other Facility committees **13**

Relationship of Ramsay Health Care to Health Professionals **13**

Central Credentialing Committee **15**

Accreditation of Medical Practitioners and Dentists **15**
- Accreditation Classifications 15
- Initial Accreditation as a Medical Practitioner or Dentist 16
- Temporary Accreditation 18
- Accreditation of locum tenens 19
- Re-Accreditation, Re-Credentialing and re-defining Scope of Clinical Practice 19
- Resignation or extended absence of an Accredited Practitioner 19
- Accredited Practitioner may request variation of Scope of Clinical Practice 20
- Review of Scope of Clinical Practice 20
- Suspension of Accreditation 21
- Termination of Accreditation 21
- Right of appeal 23
- Contracted providers 23

Accreditation of Allied Health Professionals, Independent Midwives, Nurse First Assistants and Nurse Practitioners **24**
- Accreditation subject to registration and adequate insurance 24
- The Accreditation process 24
- Review of Accreditation 25
- No right of appeal 25

Issues of concern raised about Accredited Health Professionals **25**

Continuous disclosure **26**

Research and the introduction of New Clinical Services, Procedures and Other Interventions **27**
- Research 27
- Introduction of New Clinical Services, Procedures or Other Interventions 28

Privacy and confidentiality **28**
Privacy 28
Confidential information 29
Committees 29
What confidentiality means 29
When confidentiality can be breached 29
Privacy and confidentiality obligations continue 29

Medical Council **30**
Composition 30
Objective 30
Chairperson and deputy chairperson 30
Ordinary and special meetings 31
Annual General Meeting 31
Proceedings at meetings 31
Nomination of members to the Medical Advisory Committee 32

Medical Advisory Committee **33**
Establishment and composition 33
Term of appointment and resignation of members 33
Roles 33
Meetings 34
Proceedings at meetings 35
Terms of reference 35

Credentials Committee **35**
Establishment and composition 35
Roles and processes 36
Meetings and proceedings 37

Clinical Review Committee **38**
Establishment and composition 38
Role 38
Meetings 39
Clinical Review Committee (tertiary hospital) 39

General provisions applying to committees **40**
Conflict of interests 40
Statutory immunity for committees 41

Schedule 1 - General Conditions of Accreditation **42**

Schedule 2 - Conditions associated with Accreditation Classifications **44**

Reference **45**

Document History and Version Control Table: **45**

Amendments in this release: **45**

Foreword

These By-Laws apply to all hospitals and day procedure centres operated by Ramsay Health Care at which the Board has determined they shall apply.

They will assist in the selection and retention of Health Professionals who possess the qualifications and experience to deliver high quality health care to patients.

The By-Laws require appropriate persons to:

- examine the Credentials of various categories of Health Professionals;
- define and authorise a Scope of Clinical Practice for each Health Professional in each Facility in which they wish to treat patients, which is appropriate to the Health Professional's competence and performance and the needs and capabilities of the Facility; and
- undertake ongoing assessment at appropriate intervals of the competence and performance of each Health Professional and the needs and capabilities of each Facility in which they treat patients, and, if necessary, re-define their authorised Scope of Clinical Practice in relation to each Facility.

The By-Laws also define the roles of certain individuals and the composition, roles and responsibilities of various committees that assist Ramsay Health Care to maintain positive relationships with Accredited Health Professionals based on a mutual commitment to the delivery of high quality health care.

Schedules have been developed to ensure consistent application of the processes defined in these By-Laws.

Compliance with the By-Laws and use of the Schedules by all Ramsay Health Care staff and Accredited Health Professionals is mandatory.

The By-Laws

What are these By-Laws?

1 This document sets out the current By-Laws that apply to all hospitals and day procedure centres operated by Ramsay Health Care at which the Board has determined they shall apply. These By-Laws:

1.1 implement the policies of the Board of Ramsay Health Care; and

1.2 are intended to inform those who will be affected by the By-Laws.

Authority to make and amend these By-Laws

2 The Board is empowered to make by-laws, rules and policies for the operation of its Facilities as it may deem necessary from time to time.

3 These By-Laws are authorised by the Board and may be amended by the Board as it sees fit. The Board:

3.1 may vary or revoke these By-Laws at any time; and

3.2 will review these By-Laws at least every three years.

The purposes of these By-Laws

4 These By-Laws have these purposes:

4.1 maintaining and improving safety and quality;

4.2 ensuring consistency of safety and quality across all sites;

4.3 defining the relationship between Ramsay Health Care and its Accredited Health Professionals; and

4.4 ensuring compliance with laws and standards.

Compliance with these By-Laws

5 All Ramsay Health Care staff and Accredited Health Professionals are required to comply with these By-Laws.

Reading and interpreting these By-Laws

6 Words or expressions which are capitalised have special meanings as follows:

6.1 **Accreditation** means:

6.1.1 the authorisation in writing by the Chief Executive Officer for a Health Professional to treat patients at the Facility within the Scope of Clinical Practice and in accordance with the conditions specified in that authorisation; and

6.1.2 the processes described in these By-Laws leading to that authorisation.

6.2 **Accreditation Classification** means one of the nominated classifications in By-Law 40.

6.3 **Accreditation Notification** means the formal notification from the Chief Executive Officer to a Health Professional advising the Health Professional of the Board's approval of their Accreditation or re-Accreditation and their authorised Scope of Clinical Practice.

6.4 **Accredited Allied Health Professional** means an Allied Health Professional authorised to treat patients at the Facility within a designated Scope of Clinical Practice and in accordance with any specified conditions.

6.5 **Accredited Health Professional** means an Allied Health Professional, Dentist, Independent Midwife, Medical Practitioner, Nurse First Assistant or Nurse Practitioner authorised to treat patients at the Facility within a designated Scope of Clinical Practice and in accordance with any specified conditions.

6.6 **Accredited Practitioner** means a Medical Practitioner or Dentist authorised to treat patients at the Facility within a designated Scope of Clinical Practice and in accordance with any specified conditions.

6.7 **Act** means the relevant law of the State which is intended to cover the regulation of private hospitals in that State, including any regulations made pursuant to it.

6.8 **Allied Health Professional** means a cardiac technician, chiropractor, dietician, occupational therapist, pharmacist, physiotherapist, podiatrist, psychologist, speech pathologist, social worker, rehabilitation counsellor or other category of person who provides allied health services, as determined by the Board.

6.9 **Appeal Committee** means a committee established in accordance with By-Law 93.

6.10 **Application Form** means the application form approved by Ramsay Health Care from time to time to be used by Health Professionals to apply for authorisation to treat patients at the Facility within an authorised Scope of Clinical Practice and in accordance with these By-Laws and the policies of the Facility and of Ramsay Health Care.

6.11 **Board** means the board of Ramsay Health Care Limited.

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

6.13 **Career Medical Officer** means a Medical Practitioner who is employed by the Facility to treat patients within a designated Scope of Clinical Practice under the supervision of an Accredited Practitioner.

6.14 **Central Credentialing Committee** means the committee established in accordance with By-Law 39, or such other committee, howsoever described, performing the functions of that committee.

6.15 **Chief Executive Officer (CEO)** means the person appointed by the Chief Operating Officer in collaboration with the State Manager as the senior executive (howsoever described) of the Facility and in the absence of that person the person appointed to act in that position for the time being.

6.16 **Chief Operating Officer (COO)** means the person appointed by the Board as the Chief Operating Officer of Ramsay Health Care and in the absence of that person the person appointed to act in that position for the time being.

6.17 **Clinical Department or Service** means a department or section of Accredited Practitioners in like sub-specialties, as approved by the Chief Executive Officer on the advice of the Medical Council in accordance with By-Law 18.

6.18 **Clinical Governance Unit** means the unit established by the Chief Operating Officer to advise on policy, procedures and operational matters relevant to accountability for the safety and quality of clinical care in the Facilities of Ramsay Health Care.

6.19 **Clinical Review Committee** means a committee established in accordance with By-Law 187, or such other committee, howsoever described, performing the functions of that committee.

6.20 **Consultant Emeritus** means a Medical Practitioner or Dentist who has provided distinguished service to the Facility or who otherwise is a Medical Practitioner or Dentist of outstanding merit or extraordinary accomplishment and who is designated formally by the Board as an Accredited Practitioner in the category of consultant emeritus.

6.21 **Credentialing** means the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of Health Professionals for the purpose of forming a view as to their competence, performance and professional suitability to provide safe, high quality health care services in accordance with the needs and capabilities of the Facility.

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

6.23 **Credentials Committee** means a committee established in accordance with By-Law 175, or such other committee, howsoever described, performing the functions of that committee.

6.24 **Current Fitness** is the current fitness required of a Health Professional to carry out the Scope of Clinical Practice sought or currently approved. A

person is not to be considered as having Current Fitness if that person suffers from any physical or mental impairment, disability, condition or disorder which detrimentally affects or is likely to detrimentally affect their physical or mental capacity to practice medicine or dentistry or allied health or nursing (as the case may be) and carry out the Scope of Clinical Practice sought or granted. Misuse of alcohol or other drugs is considered to be a physical or mental disorder for the purposes of these By-Laws.

6.25 **Dentist** has the same meaning as in the registration act for dentists in the State.

6.26 **Director of Clinical Services** (howsoever termed, including but not limited to Director of Nursing) means the person appointed to that position by the Chief Executive Officer after consultation with the State Manager and in the absence of that person the person appointed to act in that position for the time being.

6.27 **Director of Medical Services** (howsoever termed) means, if the Chief Executive Officer after consultation with the State Manager decides to make an appointment to such a position, the Medical Practitioner appointed to that position and in the absence of that person the person appointed to act in that position for the time being.

6.28 **Executive Management Committee** means a committee established in accordance with By-Law 23.

6.29 **Facility** means a hospital or day procedure centre of Ramsay Health Care at which the Board has determined that these By-Laws shall apply.

6.30 **Fellow Practitioner** means a Medical Practitioner not yet recognised either as a specialist in their nominated category or as a general practitioner for the purposes of the *Health Insurance Act 1973* (Cth); but training to become either a specialist or a general practitioner; and working under the supervision of a Specialist Practitioner or a General Practitioner as appropriate.

6.31 **General Conditions** are the conditions of Accreditation set out in Schedule 1 of these By-Laws, as amended from time to time

6.32 **General Practitioner** means a Medical Practitioner who is recognised as a general practitioner for the purposes of the *Health Insurance Act 1973* (Cth) and who is registered as such in the State (if the State has such a registration category).

6.33 **Health Department** means the department of government for the State with the responsibility for health in the State.

6.34 **Health Professional** means:

6.34.1 a Medical Practitioner;

6.34.2 a Dentist;

6.34.3 an Allied Health Professional;

6.34.4 an Independent Midwife;

6.34.5 a Nurse First Assistant;

6.34.6 a Nurse Practitioner; or

6.34.7 any other category, approved by the Board, of persons who provide health services.

6.35 **Independent Midwife** means a person authorised to practise midwifery in the State who works privately and independently of a hospital or health service.

6.36 **Managing Director** means the person appointed by the Board as the Managing Director of Ramsay Health Care and in the absence of that person the person appointed to act in that position for the time being.

6.37 **Medical Advisory Committee (MAC)** means a committee established in accordance with By-Law 153.

6.38 **Medical Board** means the registration board for medical practitioners in the State.

6.39 **Medical Council** means the council described in By-Law 129, comprised of all Accredited Practitioners of the Facility (except Surgical Assistants, Career Medical Officers, Registrars and Fellow Practitioners).

6.40 **Medical Executive** means the chairperson and deputy chairperson/ secretary of the Medical Council of the Facility and the Director of Medical Services if one has been appointed to the Facility.

6.41 **Medical Practitioner** has the same meaning as in the registration act for medical practitioners in the State.

6.42 **New Clinical Services, Procedures or Other Interventions** are clinical services that are new to the Facility, require more than incremental change in the way in which health care services are delivered at the Facility and:

6.42.1 have been established in other organisational settings and are deemed by a responsible body of medical opinion as clinical services, procedures or other interventions that will benefit patients; or

6.42.2 remain experimental, and therefore subject to review by a properly constituted Human Research Ethics Committee.

They may, but will not necessarily, be innovative, complex or costly.

6.43 **Nurse First Assistant** howsoever described means a nurse who is registered under the registration act for nurses in the State who assists an Accredited Practitioner in the operating theatre or elsewhere at the Facility.

6.44 **Nurse Practitioner** means a nurse who is registered under the registration act for nurses in the State as such, who is educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role.

6.45 **Ramsay Health Care** means Ramsay Health Care Ltd and its subsidiaries.

6.46 **Re-credentialing** means the formal process to re-confirm the qualifications, experience, professional standing and other relevant professional attributes of Accredited Practitioners and Accredited Allied Health Professionals for the purpose of forming a view about their ongoing competence, performance and professional suitability to continue to provide safe, high quality health services in accordance with the needs and capabilities of the Facility.

6.47 **Registrar** means a Medical Practitioner who is participating in a recognised training program in preparation for qualifying as a Specialist Practitioner.

6.48 **Research** includes investigation undertaken to gain knowledge and understanding or to train researchers.

6.49 **Scope of Clinical Practice** (sometimes called clinical privileges) means the extent of clinical practice which an Accredited Health Professional is authorised to undertake within the Facility based upon the individual's credentials, competence, performance and professional suitability and the needs and capability of the Facility. A Scope of Clinical Practice may include the use of facilities or specialised equipment or the performance of specific operations or procedures. The Scope of Clinical Practice granted to an Accredited Health Professional may vary from one Facility to another.

6.50 **Specialist Practitioner** means a Medical Practitioner who has been recognised as a specialist in their nominated category for the purposes of the *Health Insurance Act 1973* (Cth) and who is registered as such in the State (if the State has such a registration category).

6.51 **Staff Specialist** means a Specialist Practitioner appointed to and employed by or seconded to the Facility.

6.52 **State** means the state (or if applicable, territory) in which the Facility operates.

6.53 **State Manager** means the person appointed by the Chief Operating Officer to oversee the management of Ramsay Health Care facilities in one or more states or territories and in the absence of that person the person appointed to act in that position for the time being.

6.54 **Surgical Assistant** means a Medical Practitioner who assists an Accredited Practitioner in the operating theatre.

7 In the interpretation of these By-Laws, the following provisions apply unless the context requires otherwise:

7.1 headings are inserted for convenience only and do not affect the interpretation of these By-Laws;

7.2 a reference in these By-Laws to any law, legislation or legislative provision includes any statutory modification, amendment or re-enactment, and any subordinate legislation or regulations issued under that legislation or legislative provision;

7.3 a reference to a clause, part, schedule or attachment is a reference to a clause, part, schedule or attachment of or to these By-Laws;

7.4 where a word or phrase is given a defined meaning, another part of speech or other grammatical form in respect of that word or phrase has a corresponding meaning;

7.5 a word which denotes the singular also denotes the plural, a word which denotes the plural also denotes the singular, and a reference to any gender also denotes the other gender;

7.6 a reference to the word 'include' or 'including' is to be construed without limitation;

7.7 a reference to the treatment of patients "at the Facility" includes a reference to treatment provided at the Facility or provided or arranged with the direct involvement of the Facility within the meaning of s121-5 of the *Private Health Insurance Act 2007* (Cth); and

7.8 any schedules and attachments form part of these By-Laws.

8 Where the title chairperson is used in these By-Laws, the incumbent of that position for the time being may choose to use whichever designation that person so wishes.

Quorum/meetings

9 Where these By-Laws refer to a meeting (with the exception of the Medical Council) the following quorum requirements shall apply:

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

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

10 A decision may be made by a committee or group established pursuant to these By-Laws (except that established by By-Law 93) without a meeting if a consent in writing setting forth such a decision is signed by all the committee or group members, as the case may be.

11 A committee or group established pursuant to these By-Laws may permit members to participate in a particular meeting, or all meetings, by telephone, closed-circuit

television or other means of communication. The requirements of these By-Laws shall nonetheless apply to such a meeting.

Voting

12 Where voting on an issue is performed pursuant to these By-Laws, the vote of a simple majority of those present will determine the issue.

13 Unless otherwise provided in these By-Laws, if there is an equality of votes the chairperson shall have a casting vote in addition to a deliberative vote.

14 Proxy voting is not permitted.

Disputes

15 Any dispute or difference which may arise as to the meaning or interpretation of these By-Laws or as to the powers of any committee or the validity of proceedings of any meeting shall be determined by the Board.

Chief Executive Officer

16 The Chief Operating Officer (COO) in collaboration with the State Manager shall appoint a Chief Executive Officer (CEO) of the Facility.

17 The CEO shall:

17.1 be the senior officer of the Facility to whom all staff, through their respective department heads, shall be responsible;

17.2 be the spokesperson and, other than in exceptional circumstances, the channel for all formal communications to and from the Facility;

17.3 advise the Board on matters relating to the purchase of major equipment;

17.4 be responsible for the management of the Facility and its staff and resources including the provision of patient care to acceptable standards, in accordance with the policies and directives of the Board;

17.5 ensure due observance of the Act, all other statutes, these By-Laws and all other legal requirements; and

17.6 act as Secretary to the Medical Council, Medical Advisory Committee and Credentials Committee; however if a Director of Medical Services is appointed the CEO may delegate such roles to the Director of Medical Services.

18 The CEO with the advice of the Medical Council may establish Clinical Departments or Services of Accredited Practitioners to facilitate achievement of the Facility's objectives. Such Clinical Departments or Services, however, shall meet as a minimum the meeting requirements of the MAC as established in these By-Laws.

19 The CEO following consultation with the MAC shall appoint heads of the Clinical Departments or Services to hold office at the discretion of the CEO. The heads of the Clinical Departments or Services may be appointed for a maximum of four years and may be reappointed at the discretion of the CEO.

Director of Clinical Services and Director of Medical Services

20 The CEO after consultation with the State Manager shall appoint a Director of Clinical Services (howsoever named) and may appoint a Director of Medical Services on such terms and conditions as are consistent with statutory and licensing requirements and the requirements of the Facility for clinical leadership and management.

21 The CEO may delegate to the Director of Clinical Services and/or the Director of Medical Services responsibility and accountability for any or all of the following functions:

21.1 ensuring that suitable standards (including but not limited to clinical standards) are maintained to provide a satisfactory and safe environment for patients, staff, Accredited Health Professionals and others;

21.2 liaising within the Facility and with the Clinical Governance Unit about issues of clinical safety, quality and standards;

21.3 advising on matters of policy in clinical services referred by the Board or the Clinical Governance Unit;

21.4 overseeing the process of accreditation including credentialing and defining the Scope of Clinical Practice of Health Professionals;

21.5 ensuring that medical, nursing and other resources are provided at a level that will ensure a safe and optimal level of patient care;

21.6 in accordance with By-law 17.6, acting as Secretary to the Medical Council, MAC and Credentials Committee;

21.7 ensuring compliance with relevant statutory requirements;

21.8 participating actively in all activities of the Executive Management Committee;

21.9 as required, co-operating in the planning of additional facilities and services; and

21.10 ensuring availability at all times, either personally or by delegation of authority, to meet any emergency or contingency that may arise.

Executive staff

22 The CEO may appoint any other executive staff he or she deems appropriate for the Facility and may determine the role of such appointees.

Executive Management Committee

23 The Executive Management Committee shall comprise:

23.1 the CEO;

23.2 the Director of Clinical Services;

23.3 the Director of Medical Services, if one is appointed;

23.4 other executive staff; and

23.5 any other person by invitation of the CEO.

24 The CEO shall convene the Executive Management Committee on a regular basis.

25 The Executive Management Committee shall advise the CEO on operational and strategic matters relevant to the Facility including but not limited to financial, human resources and clinical matters.

Other Facility committees

26 The CEO may establish other committees for the purposes of the Facility.

27 Subject to these By-Laws, the CEO shall determine the membership, powers, authorities and responsibilities that are delegated to each committee and the administrative rules by which each committee is to operate.

Relationship of Ramsay Health Care to Health Professionals

28 The requirements for Accreditation defined in these By-Laws apply to:

28.1 all Medical Practitioners and Dentists other than Career Medical Officers, Registrars and Fellow Practitioners; and

28.2 all Allied Health Professionals, Independent Midwives, Nurse First Assistants and Nurse Practitioners other than those who are employed by the Facility and subject to the Facility's performance management procedures.

29 The CEO may determine:

29.1 following consultation with the MAC that the Accreditation requirements also will apply to Career Medical Officers, Registrars and/or Fellow Practitioners; and/or

29.2 that the Accreditation requirements also will apply to Allied Health Professionals, Independent Midwives, Nurse First Assistants and Nurse Practitioners who are employed by the Facility;

either individually or collectively and either before or after the employment or engagement of the relevant Health Professionals.

30 A Health Professional to whom the requirements for Accreditation defined in these By-Laws apply may treat patients at the Facility only if he or she has been accredited by the Board to do so.

31 Every applicant for Accreditation must acknowledge in writing that he/she will comply with and be bound by these By-Laws as amended from time to time, and by codes of conduct or codes of behaviour adopted by the Facility and/or by Ramsay Health Care from time to time.

32 A Health Professional may be accredited to treat patients at the Facility for a period of up to 5 years. The period of Accreditation shall be specified in the Accreditation Notification.

33 The CEO must not notify a Health Professional that he or she is Accredited or re-Accredited unless the CEO is satisfied that:

33.1 the credentials of the applicant have been reviewed and validated according to Ramsay Health Care policy; and

33.2 the Board has approved the Accreditation or re-Accreditation and Scope of Clinical Practice of the Health Professional.

34 An Accredited Health Professional may treat patients at the Facility:

34.1 only within the Scope of Clinical Practice specified in the Accreditation Notification; and

34.2 subject at all times to the continuing authority of the CEO.

35 The CEO or his or her delegate may refuse or withdraw permission for an Accredited Health Professional to use the Facility for the treatment of a patient if in his or her opinion the proposed treatment:

35.1 cannot be provided by the Accredited Health Professional and/or supported by the Facility at an appropriate standard of safety and quality;

35.2 is outside the authorised Scope of Clinical Practice of the Accredited Health Professional;

35.3 is likely to result in damage to the Facility's and/or Ramsay Health Care's reputation; or

35.4 is inconsistent with good professional practice.

36 The Accreditation of a Health Professional is personal and cannot be transferred to or exercised by any other person.

37 Accreditation to treat patients at the Facility gives no entitlement with respect to any other Facility.

38 The CEO, following consultation with the chairperson of the MAC and the Clinical Governance Unit, may notify the relevant professional registration board in the State if they consider that a Health Professional's competence or performance poses a material threat to the health or safety of individuals or the community.

Central Credentialing Committee

39 The Managing Director shall establish a Central Credentialing Committee which shall be responsible for advising the Board on general and specific matters relevant to credentialling, scope of clinical practice and performance review of Accredited Practitioners.

Accreditation of Medical Practitioners and Dentists

Accreditation Classifications

40 Each Accredited Practitioner shall be designated one or more of the following Accreditation Classifications with respect to each Facility to which they are accredited:

40.1 Career Medical Officer;

40.2 Consultant Emeritus;

40.3 Dentist;

40.4 Fellow Practitioner;

40.5 General Practitioner;

40.6 Registrar;

40.7 Specialist Practitioner;

40.8 Staff Specialist;

40.9 Surgical Assistant.

41 The conditions associated with each of these Accreditation Classifications are detailed in Schedule 2 to these By-Laws.

42 Each Medical Practitioner or Dentist who applies for Accreditation must apply for approval of a Scope of Clinical Practice within one or more of the following broad categories:

42.1 Non-surgical care;

42.2 Surgical care;

42.3 Surgical assisting;

42.4 Anaesthesia;

42.5 Diagnostic, interventional and/or procedural services;

42.6 Consulting services.

Initial Accreditation as a Medical Practitioner or Dentist

43 A Medical Practitioner or Dentist who wishes to be accredited to treat patients at the Facility must submit a completed Application Form to the CEO.

44 A Medical Practitioner or Dentist may apply for Accreditation to multiple Facilities using a single Application Form and may provide a single set of documents evidencing his or her credentials where provision to do so is authorised by the CEO's of the Facilities concerned.

45 The CEO may reject any application for Accreditation to the Facility. There shall be no right of appeal against a decision of the CEO to reject an application for Accreditation to the Facility.

46 The CEO shall only accept an application for Accreditation if the services proposed to be provided are likely to meet the needs of the Facility and are aligned closely with its capability, recurrent operating plan and long-term strategic directions.

47 The CEO must ensure compliance with Ramsay Health Care policy that requires specified credentials to be reviewed and/or verified for the purposes of Accreditation, including any policy regarding the form and number of professional references to be obtained.

48 The CEO must ensure that the following have been verified:

48.1 the applicant holds appropriate registration with the relevant registration board; and

48.2 the applicant holds appropriate professional indemnity insurance in accordance with Ramsay Health Care policy.

49 If the CEO accepts the application for Accreditation, he or she shall refer it to the Credentials Committee.

50 The Credentials Committee shall review all applications referred to it with respect to the qualifications, experience, competence, judgment, professional capabilities and knowledge, Current Fitness and character of and confidence held in the applicant and formulate recommendations to the MAC on each applicant's credentials and appropriate Accreditation Classification and Scope of Clinical Practice.

51 The MAC shall review the advice of the Credentials Committee and recommend to the CEO whether the application for Accreditation should be approved; and if it is recommended for approval, the appropriate Accreditation Classification and Scope of Clinical Practice.

52 The CEO must consider every recommendation of the MAC. The CEO shall submit the recommendations of the MAC together with the CEO's advice on Accreditation

including Scope of Clinical Practice to the Central Credentialing Committee through the Clinical Governance Unit. The Central Credentialing Committee, with the advice of the Clinical Governance Unit, shall advise the Board on whether and under what conditions Accreditation should be offered.

53 The Board retains discretion to determine whether Accreditation is to be offered and under what conditions, taking into account factors including but not limited to the workforce need, the capacity, capability and strategic direction of the Facility and the assessed qualifications, experience, competence, judgment, professional capabilities and knowledge, Current Fitness and character of and confidence held in the applicant for Accreditation.

54 The Board may qualify the conditions of Accreditation in any way including but not limited to a limited period of Accreditation, a limited Scope of Clinical Practice, a requirement for a mentoring or supervision program, a periodic performance review, a periodic review of Scope of Clinical Practice and/or a performance management program.

55 The CEO must notify the applicant of the Board's decision. If the Accreditation Notification confirms the Accreditation of the applicant then it must set out the particulars of the Accreditation including the Accreditation Classification, the period of Accreditation, the authorised Scope of Clinical Practice and any other conditions that will apply.

56 There shall be no right of appeal against a decision of the Board concerning the initial Accreditation or associated Scope of Clinical Practice of a Medical Practitioner or Dentist.

57 The Accreditation period shall not exceed 5 years. The applicant may re-apply for Accreditation up to 6 months before the expiry of the Accreditation period.

58 During the period of Accreditation, the CEO must ensure that the following are verified annually:

58.1 the Accredited Practitioner holds appropriate registration with the relevant registration board; and

58.2 the Accredited Practitioner holds appropriate professional indemnity insurance in accordance with Ramsay Health Care policy and standards.

59 The availability of Facility resources (including staff and physical facilities) and any obligation for the Accredited Practitioner to participate in Facility rosters will be at the discretion of the CEO and may change from time to time. The availability or allocation of theatre sessions will take into account matters including but not limited to:

59.1 the availability of theatres and nursing staff;

59.2 commercial strategies and priorities of the Facility and/or Ramsay Health Care;

59.3 Facility and/or Ramsay Health Care policy; or

59.4 the utilisation of sessions allocated previously to that Accredited Practitioner or the casemix of that Accredited Practitioner.

60 An Accredited Practitioner must comply with the conditions of the Accreditation and these By-Laws. Accreditation is subject at all times to the Accredited Practitioner complying with the General Conditions of Accreditation set out in Schedule 1 of these By-Laws, as amended from time to time. If there is any inconsistency between those General Conditions of Accreditation and any special conditions, the special conditions prevail.

Temporary Accreditation

61 The CEO (or the Director of Medical Services, where one has been appointed, with the delegated authority of the CEO) may authorise temporary Accreditation of a Medical Practitioner or Dentist, before an application for Accreditation has been determined.

62 The CEO must comply with Ramsay Health Care policy that requires specified credentials to be reviewed and/or verified for the purposes of a temporary Accreditation, including any policy regarding the number and format of professional references to be obtained and reviewed.

63 The CEO must verify that:

63.1 the applicant holds appropriate registration with the relevant registration board; and

63.2 the applicant holds appropriate professional indemnity insurance in accordance with Ramsay Health Care policy and standards.

64 The CEO must confer with the chairperson of the MAC, the head of the relevant Clinical Department or Service (if one has been established) and a senior manager in a hospital or day procedure facility within which the applicant has worked recently before authorising a temporary Accreditation including an associated Accreditation Classification and temporary Scope of Clinical Practice.

65 The CEO may approve a temporary Accreditation for a maximum period of four months from the date of advice to the applicant that the Accreditation has been approved. The CEO must specify a Scope of Clinical Practice and may attach conditions to the Accreditation at his or her discretion.

66 A temporary Accreditation enables a Medical Practitioner or Dentist to treat patients at the Facility within the specified Scope of Clinical Practice and any associated conditions, until a final determination of an application is made or until a specified date or until a specified occurrence.

67 A temporary Accreditation does not create a right to or expectation of Accreditation at a later date.

68 A Medical Practitioner or Dentist who treats patients at the Facility under a temporary Accreditation must comply with the terms of the Accreditation and these By-Laws. Accreditation is subject at all times to the Accredited Practitioner complying with the

General Conditions of Accreditation set out in Schedule 1 of these By-Laws, as amended from time to time. If there is any inconsistency between those General Conditions of Accreditation and any special conditions, the special conditions prevail.

69 Following consultation with the chairperson of the MAC, the CEO may suspend or terminate a temporary Accreditation at any time for any reason, including but not limited to the CEO holding the opinion that patient care or safety, staff welfare or safety or the reputation of the Facility or Ramsay Health Care may be impaired if the temporary Accreditation continues.

70 There shall be no right of appeal against a decision of the CEO concerning the temporary Accreditation or associated Scope of Clinical Practice of a Medical Practitioner or Dentist.

Accreditation of locum tenens

71 If an Accredited Practitioner nominates a locum tenens to provide services to his or her patients during a period of absence from the Facility, that nominee cannot treat patients at the Facility unless and until the CEO has approved their Accreditation.

Re-Accreditation, Re-Credentialing and re-defining Scope of Clinical Practice

72 Not less than three months before the date fixed for expiry of the Accreditation of a Health Professional the CEO must notify the Accredited Practitioner of the pending expiry of their Accreditation and the processes for applying for re-Accreditation including Re-credentialing and review of their Scope of Clinical Practice.

73 An Accredited Practitioner who wishes to renew their Accreditation must apply for re-Accreditation before the expiration of the term of Accreditation.

74 Subject to Ramsay Health Care policy, the processes for re-Accreditation, including processes for Re-credentialing and re-defining the Scope of Clinical Practice of Accredited Practitioners shall be the same as for an initial Accreditation, save that By-Law 56 does not apply.

75 All Accredited Practitioners shall be subject to the processes of re-Accreditation, Re-credentialing and review of their Scope of Clinical Practice at least once every five years.

Resignation or extended absence of an Accredited Practitioner

76 An Accredited Practitioner who intends to cease treating patients at the Facility either indefinitely or for an extended period must notify his or her intention to the CEO. Accreditation shall be taken to be relinquished from the date specified in the notification.

77 An Accredited Practitioner to whom By-Law 76 applies must, whenever practicable, advise the CEO prior to the cessation of his or her normal patient bookings and clinical activities and must ensure that upon cessation of clinical activities any remaining patients are either discharged or referred with appropriate consent to the care of another Health Professional to ensure continuous cover.

78 It is the responsibility of the Accredited Practitioner to advise their own patients and any known carers or legal guardians of their patients of any proposed changes to their care arrangements.

Accredited Practitioner may request variation of Scope of Clinical Practice

79 An Accredited Practitioner may request a variation to his or her Scope of Clinical Practice.

80 The processes for variation of Scope of Clinical Practice are the same as for an initial determination of Scope of Clinical Practice. The CEO may waive the requirement for the Accredited Practitioner to submit evidence of specific credentials, however, if the CEO is satisfied that there has been no change to those credentials since the date on which the Accredited Practitioner's Scope of Clinical Practice last was determined.

Review of Scope of Clinical Practice

81 At any time any of the CEO, the Director of Clinical Services, the Director of Medical Services, the chairperson of the Medical Council, the head of a Clinical Department or Service in which an Accredited Practitioner practises, the Clinical Governance Unit or the Board may request a review of the Scope of Clinical Practice of an Accredited Practitioner.

82 The CEO following consultation with the chairperson of the MAC may alter the authorised Scope of Clinical Practice of an Accredited Practitioner pending a review of that Scope of Clinical Practice.

83 The CEO may elect to commission a review of the Scope of Clinical Practice of the Accredited Practitioner by an independent person or persons. The review may include but need not be limited to consideration of the Credentials, competence, performance and Current Fitness of the Accredited Practitioner; an assessment of confidence in the Accredited Practitioner; and an assessment of the needs and capability of the Facility insofar as they are related to the Accredited Practitioner's Scope of Clinical Practice.

84 If the CEO elects not to commission an independent review, he or she shall refer the request for review of the Scope of Clinical Practice of an Accredited Practitioner to the Credentials Committee, which shall conduct the review according to its usual processes for Credentialing and defining the Scope of Clinical Practice and advise the MAC of its recommendations.

85 The Accredited Practitioner who is the subject of a review must:

85.1 be informed in writing of the proposed review including reasonable particulars about any issues of concern and the potential outcomes of the review;

85.2 be provided with a copy of these By-Laws;

85.3 be provided with an opportunity to make a submission to the review; and

85.4 cooperate with the reviewers, including providing information reasonably requested to inform the review.

86 The results of the review shall be submitted to the Central Credentialing Committee through the Clinical Governance Unit. The Central Credentialing Committee shall consult with the CEO and shall recommend to the Board appropriate action which may include termination of the Accreditation, revision of the Accreditation Classification or Scope of Clinical Practice of the Accredited Practitioner or imposition of conditions on the Accreditation.

87 The CEO shall advise the Accredited Practitioner in writing within five working days of the Board's decision and shall implement the decision immediately.

88 Subject to rights of appeal on the part of the Accredited Practitioner, any variation in an Accredited Practitioner's Accreditation Classification, conditions of Accreditation or Scope of Clinical Practice constitutes a consequential variation to the Accreditation of the Accredited Practitioner.

Suspension of Accreditation

89 The CEO, following consultation with the chairperson of the MAC, the State Manager and the Clinical Governance Unit, may by notice in writing suspend (in part or in full) the Accreditation of an Accredited Practitioner until further notice if in the opinion of the CEO:

89.1 to do so would be in the interests of patient care or safety;

89.2 to do so would be in the interests of staff welfare or safety;

89.3 the Accredited Practitioner has materially breached any conditions of Accreditation, including failing to comply with these By-Laws;

89.4 the conduct of the Accredited Practitioner compromises the efficient operation or the interests of the Facility;

89.5 the conduct of the Accredited Practitioner is likely to harm the reputation of the Facility and/or of Ramsay Health Care; or

89.6 serious and unresolved issues of concern (not otherwise falling within By-Law 89.1 to 89.5) have been raised in relation to the Accredited Practitioner.

Termination of Accreditation

90 The Board may terminate the Accreditation of an Accredited Practitioner if:

90.1 the Accredited Practitioner ceases to be registered;

90.2 the Accredited Practitioner fails to observe a General Condition or a special condition of Accreditation;

90.3 the Accredited Practitioner makes a disclosure pursuant to the continuous disclosure requirements of these By-Laws where, in light of the facts and circumstances disclosed, the Board considers continued Accreditation to be untenable;

90.4 the Accredited Practitioner has been unable to perform his or her patient care and treatment duties for a continuous period of six months;

90.5 if the Accredited Practitioner is authorised to admit patients, he or she has not admitted any patients for a continuous period of six months;

90.6 the Accredited Practitioner is found guilty of professional misconduct and/or unsatisfactory professional conduct (howsoever termed) by any inquiry, investigation or hearing by any disciplinary body or professional standards organisation;

90.7 the Accredited Practitioner has engaged in any conduct which in the opinion of the Board is likely to bring the Accredited Practitioner into professional disrepute;

90.8 the Accredited Practitioner has engaged in any conduct which in the opinion of the Board is likely to harm the reputation of the relevant Facility or of Ramsay Health Care;

90.9 the Accredited Practitioner does not have the continuing confidence of the Board or the Board does not regard the Accredited Practitioner as having Current Fitness; or

90.10 the Facility ceases to provide support services required within the Scope of Clinical Practice of the Accredited Practitioner.

91 The CEO shall notify an Accredited Practitioner in writing of the termination of his or her Accreditation, including the reasons for it, and shall forward a copy of the By-laws to the Accredited Practitioner with the written notification.

Right of appeal

92 Subject to By-Laws 56, 70, 101 and 102, an Accredited Practitioner may appeal a decision in relation to suspension, variation or termination of their Accreditation, including any variation to their authorised Scope of Clinical Practice. An appeal must be lodged in writing with the CEO within 14 days of notification by the CEO of the decision.

93 The Board must establish an Appeal Committee to hear an appeal, comprising:

93.1 a nominee of the Board;

93.2 a nominee of the Medical Executive; and

93.3 a nominee of the relevant professional college or, if there is no nomination or the nominee is unavailable, a person nominated by the Board who works in the same specialty field as the appellant.

94 The nominee of the Board shall be the chairperson of the Appeal Committee.

95 An appellant must be provided with appropriate notice by the Appeal Committee and be given the opportunity to make a submission to the Appeal Committee. The Appeal Committee shall determine whether the submission shall be in writing, in person or both. Where a written submission is requested by the Appeal Committee, it must be made within four weeks of the request or longer if agreed with the chairperson of the Appeal Committee.

96 Neither an appellant nor any other party to an appeal can be represented by a legal practitioner or otherwise at a meeting of the Appeal Committee.

97 The chairperson of the Appeal Committee shall determine any question of procedure in relation to that committee.

98 The Appeal Committee shall make a written recommendation to the Board. The Board shall then make a decision which will be binding on the appellant.

99 The CEO shall notify the appellant in writing of the Board's decision as soon as reasonably possible after receiving the Board's advice, and implement the decision immediately

Contracted providers

100 If a contract provides for the delivery of clinical services (such as medical imaging or pathology) by a third party contractor to the patients of the Facility, the contract may:

100.1 provide that only Medical Practitioners and Dentists who have been Accredited to treat their patients at the Facility may provide the clinical services; or

100.2 require the contractor to ensure that:

100.2.1 the Credentials and professional indemnity insurance status of the Medical Practitioners and Dentists who provide the contracted

services are strictly verified by the third party in accordance with Ramsay Health Care policy and are consistent with the contractual requirements; and

100.2.2 the Medical Practitioners and Dentists who provide the services do so only within the Scope of Clinical Practice which is specified in the contract as generally applicable to all Medical Practitioners or Dentists providing the services, unless they have been Accredited specifically by the Facility as Accredited Practitioners with a modified Scope of Clinical Practice.

101 A contract for the delivery of a clinical service by a third party contractor to the patients of the Facility must enable the CEO to withdraw authority for any Medical Practitioner or Dentist to provide all or some of the contracted services to patients of the Facility. There shall be no right of appeal against a decision made pursuant to this By-Law.

102 The Accreditation of a Medical Practitioner or Dentist who provides services on behalf of a third party contractor to the patients of the Facility shall terminate with the contract pursuant to which those services are provided. There shall be no right of appeal against the termination of an Accreditation pursuant to this By-Law.

Accreditation of Allied Health Professionals, Independent Midwives, Nurse First Assistants and Nurse Practitioners

Accreditation subject to registration and adequate insurance

103 Prior to the Accreditation of an Allied Health Professional, Independent Midwife, Nurse First Assistant or Nurse Practitioner pursuant to these By-Laws:

103.1 where a relevant registration process applies, the CEO shall ensure that the applicant is registered according to statutory requirements; and

103.2 the CEO shall ensure that the professional indemnity insurance held by the applicant is adequate and in accordance with Ramsay Health Care policies.

The Accreditation process

104 The provisions of By-Laws 43 to 80 inclusive and of By-Laws 100 to 102 inclusive (as applicable) shall apply to the Accreditation of Allied Health Professionals, Independent Midwives, Nurse First Assistants and Nurse Practitioners (to the extent possible) with the words:

104.1 "Accredited Allied Health Professional" or "Accredited Independent Midwife" or "Accredited Nurse First Assistant" or "Accredited Nurse Practitioner", as appropriate, being deemed to apply where the term "Accredited Practitioner" is stated therein; and

104.2 "Allied Health Professional" or "Independent Midwife" or "Nurse First Assistant" or "Nurse Practitioner", as appropriate, being deemed to apply where the term "Medical Practitioner" or "Dentist" is stated therein.

Review of Accreditation

105 The CEO may at any time, taking into account such advice as he or she deems necessary to assist in decision-making, review, suspend, terminate, and/or change the conditions associated with, the Accreditation of an Allied Health Professional, Independent Midwife, Nurse First Assistant or Nurse Practitioner.

No right of appeal

106 There shall be no right of appeal against a decision concerning the Accreditation, re-Accreditation or Scope of Clinical Practice of Allied Health Professionals, Independent Midwives, Nurse First Assistants or Nurse Practitioners, including a decision to change an authorised Scope of Clinical Practice, suspend or terminate Accreditation or change any other conditions associated with Accreditation.

Issues of concern raised about Accredited Health Professionals

107 The CEO of the Facility may make inquiries regarding any issue of concern in relation to an Accredited Health Professional if the CEO considers that any of the following consequences may occur:

107.1 patient health or safety could be compromised;

107.2 the efficient operation of the Facility could be hindered;

107.3 the reputation of the Facility or of Ramsay Health Care could be threatened;

107.4 the interests a patient or someone engaged in or at the Facility could be affected adversely; or

107.5 a law has been, or may be, contravened.

108 The CEO shall advise the Accredited Health Professional in respect of whom the issue of concern has been raised, in the presence of the Chairman of the MAC or his or her delegate, of the substance of the issue of concern and provide the Accredited Health Professional with an opportunity to respond.

109 If, having considered the Accredited Health Professional's response (if any), then:

109.1 the CEO shall advise the Clinical Governance Unit of the substance of any serious issue of concern and the steps proposed to resolve it;

109.2 if in the opinion of the CEO the matter can be dealt with appropriately by reviewing the Accredited Health Professional's Scope of Clinical Practice, the CEO may request a review of the Accredited Health Professional's Scope of Clinical Practice in accordance with By-Laws 81 to 88;

109.3 if in the opinion of the CEO the matter cannot be dealt with appropriately by a review of the Accredited Health Professional's Scope of Clinical Practice, the CEO in consultation with the Chairman of the MAC may establish a committee to consider the matter further; and

109.4 the CEO may suspend or impose conditions on the Accreditation, including the Scope of Clinical Practice, of the Accredited Health Professional until such time as the CEO is satisfied that the issue of concern has been resolved.

110 A committee to assist the CEO established under By-Law 109.3:

110.1 must ensure the Accredited Health Professional has been advised in writing of the particulars of the issue of concern and invite the Accredited Health Professional to respond;

110.2 may invite the Accredited Health Professional to meet with the committee in person; and

110.3 must provide the CEO with its written conclusions and/or opinions supported by reasons.

111 Following consideration of the committee's advice, the CEO:

111.1 shall advise the Board, through the Clinical Governance Unit, of any action he or she considers necessary to address the issue of concern including terminating or suspending the Accreditation of, or imposing conditions on, the Accredited Health Professional's Accreditation; and

111.2 shall advise the Accredited Health Professional of the Board's decision as soon as reasonably possible after receiving the Board's advice, and implement the decision immediately.

Continuous disclosure

112 Every Accredited Health Professional must keep the CEO of the Facility continuously informed of matters which have a material bearing upon:

112.1 the Credentials of the Health Professional;

112.2 the Scope of Clinical Practice of the Health Professional;

112.3 the ability of the Health Professional to deliver health care services to patients safely within his or her authorised Scope of Clinical Practice; and

112.4 the Health Professional's professional indemnity insurance status.

113 Without limiting the scope of the obligations described in By-Law 112, an Accredited Health Professional must advise the CEO in writing as soon as possible but at least within fourteen days if any of the following occur:

113.1 he or she ceases to be registered or is suspended from registration under the relevant professional registration laws;

113.2 any conditions, limitations or restrictions are imposed by a registration board in relation to his or her practice;

113.3 an adverse finding is made against him or her by any registration, disciplinary, investigative or professional body;

113.4 his or her appointment to, accreditation at or scope of clinical practice at, any other facility, hospital or day procedure centre is altered in any way other than at the request of the Health Professional;

113.5 he or she incurs an illness or disability which may adversely affect his or her Current Fitness;

113.6 he or she is charged with or convicted of any serious criminal offence or breach of any laws that regulate the provision of health care or health insurance; or

113.7 he or she ceases to hold professional indemnity insurance in accordance with Ramsay Health Care policy and standards or has his or her professional indemnity insurance made conditional or not renewed.

Research and the introduction of New Clinical Services, Procedures and Other Interventions

Research

114 Research involving human subjects that is proposed to be conducted in or at the Facility shall only commence if:

114.1 a nominated member of the staff of the Facility or an Accredited Practitioner or Accredited Allied Health Practitioner will be accountable for the conduct of the research;

114.2 the CEO, with the advice of the Clinical Governance Unit, is satisfied that appropriate indemnity and/or insurance arrangements are in place;

114.3 it has been approved by an appropriately constituted Ethics Committee in accordance with National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (**the National Statement**) and it shall be conducted in accordance with any approvals provided by that committee; and

114.4 it has been approved by the Board, with advice from the CEO and/or his or her delegate in accordance with Ramsay Health Care policy.

115 If the proposed Research involves the treatment of patients at the Facility by an Accredited Health Professional, it shall not commence unless the treatment is consistent with the Scope of Clinical Practice of the relevant Health Professional granted in accordance with these By-Laws.

116 If there is doubt about whether a proposed activity constitutes Research or quality assurance or some other activity, the CEO with advice from the Clinical Governance Unit shall make a determination about the nature of the activity.

Introduction of New Clinical Services, Procedures or Other Interventions

117 An Accredited Practitioner who proposes to perform a New Clinical Service, Procedure or Other Intervention must apply to the CEO for approval.

118 The CEO shall refer the application to the Credentials Committee which shall advise the MAC on the safety, efficacy and role of the New Clinical Service, Procedure or Other Intervention in the context of the Facility's needs and capability.

119 The MAC, taking account of the advice of the Credentials Committee, shall advise the CEO:

119.1 whether, and under what conditions, the New Clinical Service, Procedure or Other Intervention could be introduced safely to the Facility; and

119.2 whether the New Clinical Service, Procedure or Other Intervention is consistent with the Accredited Practitioner's Scope of Clinical Practice.

120 The CEO may seek additional advice about the financial, operational or clinical implications of the introduction of the New Clinical Service, Procedure or Other Intervention.

121 The CEO may refuse permission for the introduction of a New Clinical Service, Procedure or Other Intervention.

122 Before approving the introduction of a New Clinical Service, Procedure or Other Intervention the CEO must:

122.1 be satisfied that the New Clinical Service, Procedure or Other Intervention is consistent with the capability, recurrent operating plan and long-term strategic directions of the Facility;

122.2 where the New Clinical Service, Procedure or Other Intervention involves Research, be satisfied that the requirements of By-Laws 114 to 115 have been met;

122.3 be satisfied that the appropriate indemnity and/or insurance arrangements are in place; and

122.4 notify the Central Credentialing Committee through the Clinical Governance Unit.

Privacy and confidentiality

Privacy

123 Accredited Health Professionals shall manage, and assist the Facility to manage, all matters related to the privacy of information in compliance with the National Privacy Principles established by the *Privacy Act 1988* (Cth) and in compliance with the various statutes governing the privacy of health information within different State and Territory jurisdictions.

Confidential information

124 Subject to By-Law 127, every Accredited Health Professional must keep confidential the following information:

124.1 business information concerning Ramsay Health Care or the Facility;

124.2 information concerning the insurance arrangements of Ramsay Health Care;

124.3 the proceedings for the Accreditation including designation of Scope of Clinical Practice of the Health Professional; and

124.4 information concerning any patient.

Committees

125 All information made available to or disclosed in the context of a committee or sub-committee of the Facility shall be kept confidential unless the information is of a general kind and disclosure outside the committee of sub-committee is authorised specifically by the committee or sub-committee.

What confidentiality means

126 The confidentiality requirements of By-Laws 124 and 125 prohibit the recipient of the confidential information from using or disclosing it for any unauthorised purpose, copying it, reproducing it or making it public.

When confidentiality can be breached

127 The confidentiality requirements of By-Laws 124 and 125 do not apply in the following circumstances:

127.1 where disclosure is required or specifically authorised by law;

127.2 where use and/or disclosure of personal information is consistent with By-Law 123;

127.3 where disclosure is required by a regulatory body in connection with the Health Professional, the Facility or Ramsay Health Care;

127.4 where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or

127.5 where disclosure is required in order to perform a requirement of these By-Laws.

Privacy and confidentiality obligations continue

128 The privacy and confidentiality requirements of these By-Laws continue with full force and effect after the Health Professional ceases to be Accredited to any Facility.

Medical Council

Composition

129 All Accredited Practitioners (except Surgical Assistants, Career Medical Officers, Registrars and Fellow Practitioners) and the Director of Medical Services (where one has been appointed) of the Facility shall be members of the Medical Council of the Facility.

Objective

130 The Medical Council shall provide a forum for communication between the Board, the Clinical Governance Unit, the Facility and Accredited Practitioners to facilitate the safe provision of patient care.

131 The Medical Council shall nominate members for appointment to the MAC and to Facility committees as required.

Chairperson and deputy chairperson

132 At each Annual General Meeting the Medical Council shall elect a chairperson and deputy chairperson who shall hold office until the next succeeding Annual General Meeting. The chairperson and deputy chairperson, together with the Director of Medical Services if one has been appointed, shall be known jointly as the Medical Executive.

133 The chairperson of the Medical Council, who also shall act as chairperson of the MAC, shall:

- 133.1 assist with effective communication and representation of the opinions, policies, reports, concerns and needs of the Accredited Practitioners to the Facility;
- 133.2 preside at, and be responsible for, the agenda of all meetings of the Medical Council and the MAC; and
- 133.3 facilitate the MAC reviewing and confirming the support of Accredited Practitioners for policies or rules of the Facility as they affect Accredited Practitioners.

134 The deputy chairperson of the Medical Council shall perform such duties as may be assigned to him or her by the Medical Council and the MAC as the case may be.

135 Should a vacancy occur in the position of chairperson or deputy chairperson it shall be filled by an Accredited Practitioner elected by the MAC from amongst its members until the next ordinary meeting of the Medical Council at which a replacement shall be elected.

136 No person shall hold office as the chairperson of the Medical Council for a period exceeding four consecutive years unless approved in writing by the COO or delegate.

137 No office bearer of the Medical Council nor any of its members is entitled to represent that they individually or collectively represent Ramsay Health Care or the Facility,

other than with the written permission of the CEO. The marks, logos and symbols of Ramsay Health Care and its Facilities may only be used for authorised purposes.

Ordinary and special meetings

138 Ordinary meetings of the Medical Council shall be held as required. The meetings shall be held at a time and place determined by the Medical Executive in conjunction with the CEO provided that at least 14 days' written notice of the meeting is given to members of the Medical Council specifying the business to be transacted.

139 A special meeting of the Medical Council may be called by the chairperson of the Medical Council subject to the approval by the CEO. At least seven days notice of a special meeting shall be given in writing to all members of the Medical Council entitled to attend such a meeting.

140 The quorum of the Medical Council for all purposes shall be the number of the active members of the Medical Council, as defined in By-Law 144, present in person at an ordinary or special meeting as determined by the Medical Executive from time to time, taking into consideration the size of the Medical Council, provided that the quorum shall comprise no less than three of the active members of the Medical Council present in person at an ordinary or special meeting.

Annual General Meeting

141 An annual general meeting of the Medical Council shall be held once in every calendar year and not more than 15 months after the preceding annual general meeting.

142 Written notice of the annual general meeting of the Medical Council, together with a copy of the agenda for that meeting, shall be given not less than 14 days prior to the date of the meeting.

Proceedings at meetings

143 Only those Accredited Practitioners who are in attendance at a meeting of the Medical Council are entitled to vote. There shall be no proxy vote.

144 Only active members of the Medical Council shall be eligible to vote and stand for office for the Medical Council, MAC or any office bearer or committee position. An active member of the Medical Council means an Accredited Practitioner (other than a Surgical Assistant, Consultant Emeritus, Career Medical Officer or Fellow Practitioner) who utilises the Facility on a regular basis as determined by the CEO on the basis of an assessment of activity over the prior six month period (taking into account normal conference, holiday and sick leave). Utilisation of the Facility on a regular basis means:

144.1 for an anaesthetist or proceduralist, utilising a regularly allocated operating list at least monthly; or

144.2 for a physician or general practitioner, an average of at least one Facility admission per fortnight; or

144.3 other work, attendance or reporting on a regular active basis each fortnight; or

144.4 participation in the Facility-administered roster for the day to day delivery of care; or

144.5 undertaking teaching or other approved activity such as research on a regular basis for or on behalf of the Facility.

145 All questions shall be decided by a show of hands or, where demanded by a member entitled to vote, by a secret ballot.

146 The chairperson of the Medical Council shall have a deliberative vote and, where there is an equality of votes, a casting vote.

147 Minutes of all meetings of the Medical Council shall be recorded by the CEO or delegate and distributed to all those entitled to attend meetings of the Medical Council prior to the next meeting.

148 No business shall be considered at a meeting of the Medical Council until the minutes of the previous meeting have been confirmed or otherwise disposed of.

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

Nomination of members to the Medical Advisory Committee

150 At each annual general meeting, the Medical Council shall nominate from amongst its members at least five Accredited Practitioners for appointment by the CEO as members of the MAC.

151 The Medical Council's nominations for membership of the MAC must include:

151.1 if the CEO has established Clinical Departments or Services in accordance with By-Law 18, the head of each such Clinical Department or Service;

151.2 if anaesthetic services are provided at the Facility, at least one Accredited Practitioner who is an anaesthetist; and

151.3 at least one Accredited Practitioner from any other major specialty groups of the Facility as determined by the Medical Executive and the CEO.

152 An Accredited Practitioner from a major specialty group from which nominations are sought may nominate himself or herself or another Accredited Practitioner for membership of the MAC. If only one Accredited Practitioner from a major specialty group from which nominations are sought is nominated, the Medical Council may accept that nomination for appointment to the MAC. In the event that two or more Accredited Practitioners are nominated from a major specialty group from which nominations are sought, the Medical Council shall hold a ballot of its members to determine which candidate it shall nominate for appointment to the MAC. Any dispute regarding the procedure or results of any ballot held under this By-Law shall be determined by the Board in accordance with By-Law 15.

Medical Advisory Committee

Establishment and composition

153 The CEO shall establish and maintain a MAC comprising:

153.1 the CEO, the Medical Executive and the Director of Clinical Services; and

153.2 those persons nominated by the Medical Council in accordance with By-Laws 150 to 152.

154 The MAC must include at least one person from those major specialty groups of the Facility as determined by the Medical Executive and the CEO.

155 At least five of the persons appointed to the MAC must be Accredited Practitioners.

156 A MAC may co-opt the services of any other person (including persons who are not Accredited Practitioners) whether for a specific time or generally, as it sees fit. A person co-opted to assist a MAC has no voting rights.

Term of appointment and resignation of members

157 The members of the MAC nominated by the Medical Council have a term of appointment of two years commencing from the end of the Annual General Meeting of the Medical Council at which they are nominated.

158 Any member of the MAC nominated by the Medical Council who has served on the MAC for three consecutive terms is ineligible to be appointed to the MAC for the immediately succeeding term unless the appointment is approved in writing by the CEO.

159 Any Accredited Practitioner who is a member of a MAC may resign from the position with one month's prior written notice to the CEO and the Medical Council.

160 If a member of the MAC resigns, the Medical Council shall nominate a replacement member in accordance with the procedure described in By-Laws 150 to 152.

Roles

161 The MAC is an advisory committee to the CEO. The roles of the MAC are:

161.1 to be the formal organisational structure through which the views of the Accredited Practitioners of the Facility are formulated and communicated;

161.2 to provide a means whereby Accredited Practitioners can participate in the policy-making and planning processes of the Facility;

161.3 to plan and manage a continuing education program for members of the Medical Council or junior medical staff where appropriate;

161.4 to advise the CEO on the clinical organisation of the Facility;

161.5 to assist in identifying health needs of the community and to advise the CEO on services that may be required to meet those needs;

161.6 to participate in the planning and implementation of quality programs;

161.7 to endeavour to ensure that the level of patient care provided by the Facility is optimised given local resources;

161.8 to ensure that a process for review of clinical outcomes and patient management is established and executed according to these By-Laws;

161.9 to review the recommendations of the Credentials Committee and advise in relation to:

161.9.1 applications for Accreditation and re-Accreditation of Health Professionals in accordance with these By-Laws;

161.9.2 the Scope of Clinical Practice of applicants recommended for Accreditation or re-Accreditation;

161.9.3 the Scope of Clinical Practice of Accredited Practitioners whose Scope of Clinical Practice has been subject to review; and

161.9.4 applications for the introduction of New Clinical Services, Procedures and Other Interventions;

and in each case make recommendations to the CEO; and

161.10 to establish a Clinical Review Committee in accordance with By-Law 187.

162 Each Clinical Department or Service shall provide a report or minutes of its meetings to the MAC on a regular basis.

163 No member of a MAC is entitled to represent that individually or collectively they represent Ramsay Health Care or the Facility, other than with the written permission of the CEO. The marks, logos and symbols of Ramsay Health Care and its Facilities may only be used for authorised purposes.

Meetings

164 Ordinary meetings of the MAC must be held not less than four times per year at a time and place determined by the chairperson of the MAC in consultation with the CEO, provided that at least 14 days notice must be given of every ordinary meeting.

165 A special meeting of the MAC may be called by the chairperson of the MAC at any time subject to the approval of the CEO. The members of the MAC must be given at least seven days notice of a special meeting.

166 Notice of a meeting must specify the business to be considered; and in the absence of unanimous agreement of the members of the MAC to the contrary, no other business will be considered.

167 In an emergency, the CEO may act without advice from the MAC in circumstances where that advice ordinarily would be required. The MAC must consider the issue at a subsequent meeting.

Proceedings at meetings

168 Members of the MAC are entitled to vote at its meetings.

169 All questions shall be decided by a show of hands. The chairperson shall conduct a secret ballot where at least one of the members of the MAC requests it.

170 The chairperson of the MAC shall have a deliberative vote and, where there is an equality of votes, a casting vote.

171 The CEO or delegate shall record minutes of all meetings of the MAC. Those minutes shall be distributed to the members of the MAC prior to their next meeting.

172 The MAC shall not proceed to discuss new business until it has considered and dealt with the accuracy of the minutes for the immediately preceding meeting. Consideration of previous minutes is limited to their accuracy.

173 If a meeting of the MAC resolves that the minutes of a preceding meeting are accurate, the chairperson shall sign a copy of them. The chairperson's signature is evidence of their accuracy.

Terms of reference

174 The CEO shall develop terms of reference for the MAC that accord with relevant regulatory requirements.

Credentials Committee

Establishment and composition

175 The CEO shall establish a Credentials Committee unless the MAC assumes the responsibilities of the Credentials Committee in accordance with By-Law 179.

176 Membership of the Credentials Committee shall comprise:

176.1 the Medical Executive;

176.2 at least one nominee of each of the Clinical Departments or Services of anaesthetics, medicine and surgery (if such Clinical Departments or Services have been established or if not at least 3 Accredited Practitioners nominated annually by the Medical Council); and

176.3 a nominee of the head of the Clinical Department or Service relevant to the application(s) for Accreditation, where such Clinical Departments or Services have been established; or

176.4 if a Clinical Department or Service has not been established, an Accredited Practitioner in the relevant speciality; or

176.5 if there are no Accredited Practitioners in the relevant speciality, a Medical Practitioner or Dentist who practises in that specialty nominated by the relevant professional body; or

176.6 if there is no suitable nomination by the relevant professional body, a Medical Practitioner or Dentist practising in the relevant specialty appointed by the CEO.

177 The chairperson of the Credentials Committee shall be elected for an annual term from the Accredited Practitioner members of the committee.

178 The CEO and Director of Clinical Services may attend meetings of the Credentials Committee but shall not have the right to vote at such meetings.

179 In consultation with the MAC, the CEO may elect not to establish a Credentials Committee, in which case the MAC will undertake the responsibilities of the Credentials Committee as defined in these By-Laws.

Roles and processes

180 The Credentials Committee is an advisory committee to the MAC.

181 The role of the Credentials Committee shall be to:

181.1 ensure that each of its members is aware of their obligations to act fairly and without bias and to avoid conflicts of interest;

181.2 advise the CEO through the MAC on the application of Ramsay Health Care's policies for verification of credentials of applicants for Accreditation or re-Accreditation or when considering a request for a review of Scope of Clinical Practice of an Accredited Practitioner;

181.3 develop criteria for and plan and monitor the effectiveness of a programme for the delineation of Scope of Clinical Practice of Medical Practitioners and Dentists, where required by the Board;

181.4 consider, in relation to every application referred to it for Accreditation or for review of an Accredited Practitioner's Scope of Clinical Practice:

181.4.1 the qualifications, experience, professional standing and other relevant professional attributes of each Health Professional for the purposes of forming a view about their competence, performance, Current Fitness, character of and confidence held in the applicant and professional suitability; and

181.4.2 the needs and capabilities of the Facility;

and make recommendations to the MAC on Accreditation or re-Accreditation and the appropriate Scope of Clinical Practice for each applicant;

181.5 consider applications by Accredited Practitioners for review of their authorised Scope of Clinical Practice and make recommendations to the MAC;

181.6 if requested by any of the CEO, the Director of Clinical Services, the Director of Medical Services, the chairperson of the Medical Council, the

head of the Clinical Department or Service in which an Accredited Practitioner practises, the Clinical Governance Unit or the Board, review the current Scope of Clinical Practice of the Accredited Practitioner and, following due consideration and taking into account the qualifications, experience, competence, professional performance, Current Fitness, professional suitability of and confidence held in the Accredited Practitioner and the needs and capabilities of the Facility, make recommendations concerning amendment or revocation of the Accredited Practitioner's Scope of Clinical Practice and/or Accreditation to the Facility.

182 In undertaking its responsibilities, the Credentials Committee must take account of the following:

182.1 whether, and to what extent, the qualifications, experience, skills and training of each applicant for Accreditation support the Classification of Accreditation and Scope of Clinical Practice sought by the applicant;

182.2 the character and standing of each applicant, and whether each applicant is a suitable person to practice at that Facility;

182.3 whether the Facility can support the Scope of Clinical Practice proposed by each applicant; and

182.4 whether in its opinion each applicant will continue to observe the current policies and processes of the Facility.

183 The Credentials Committee may request any applicant for Accreditation or Re-Accreditation or any Accredited Practitioner whose Scope of Clinical Practice is under review to provide evidence within a reasonable period of time of any aspect of their qualifications, experience, competence, professional performance, Current Fitness and professional suitability and/or to submit written material in support of their requested Scope of Clinical Practice and/or to present in person to the Committee.

184 The Credentials Committee may recommend conditions on the Scope of Clinical Practice of any applicant for Accreditation or Re-Accreditation or any Accredited Practitioner whose Scope of Clinical Practice is under review, including, without limitation, requirements for participation in a formal mentoring and/or supervision program, requirements for monitoring and/or review of performance and requirements for procedural throughput within a designated period.

Meetings and proceedings

185 The requirements for meetings and proceedings for the Credentials Committee shall be the same as those provided for the MAC in By-Laws 164 to 173.

186 The Credentials Committee shall be provided with appropriate administrative support by the Facility.

Clinical Review Committee

Establishment and composition

187 The MAC shall establish a Clinical Review Committee comprising:

187.1 in the case of the Facility where Clinical Departments or Services are established, one nominee from each of the Clinical Departments or Services; or

187.2 where Clinical Departments or Services are not established, a nominee from each major specialty group; and

187.3 the CEO, Director of Clinical Services and Director of Medical Services (where appointed) (or their delegate).

188 Other relevant persons may be co-opted as determined by the committee.

189 The chairperson of the Clinical Review Committee shall be elected for an annual term by the members of the committee from the Accredited Practitioner members of the committee.

190 As an alternative to creating a separate Clinical Review Committee, the MAC may assume the responsibilities of the Clinical Review Committee provided an appropriate mix of specialties is represented on the MAC or can be achieved through co-opting relevant persons.

Role

191 The Clinical Review Committee shall:

191.1 be responsible for clinical leadership of safety and quality at the Facility;

191.2 develop and oversee the implementation of an adequate clinical review and quality improvement program in liaison with Clinical Departments or Services for each 12 month period;

191.3 monitor the clinical review and quality improvement activities of the Facility and advise the CEO through the MAC of their adequacy and compliance with applicable statutory requirements;

191.4 review reports from the Clinical Departments or Services (where in existence), on clinical review and quality improvement activities undertaken;

191.5 review the action taken by the Clinical Departments or Services (where in existence), regarding the clinical review and quality assurance activities;

191.6 review the results of the clinical indicator program including rates of unplanned transfers in and out of the Facility and in and out of special care units, returns to theatre and deaths and advise the CEO through the MAC of the appropriate action to be taken in respect of these results; and

191.7 advise the CEO through the MAC of actions that need to be taken to assure and improve effective clinical review and quality improvement activities and programs at the Facility.

Meetings

192 Meetings of the Clinical Review Committee shall be held no less than four times per year.

193 Minutes of all meetings of the Clinical Review Committee shall be recorded by the CEO or delegate.

194 Minutes shall be submitted to the MAC and also distributed to all those entitled to attend meetings of the Clinical Review Committee prior to the next meeting.

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

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

Clinical Review Committee (tertiary hospital)

197 A Facility that operates in a tertiary hospital environment may organise clinical review through the Clinical Departments or Services as a substitute for a separate Clinical Review Committee if it can be demonstrated to the satisfaction of the CEO that such processes meet the minimum requirements of the Clinical Review Committee set out in By-Law 187 and incorporate appropriate reporting to the MAC and the CEO.

198 The Clinical Departments or Services shall provide to the MAC such reports and information as are required from time to time.

General provisions applying to committees

Conflict of interests

199 If a member of any committee established under these By-Laws or any person authorised to attend any committee meeting has a direct or indirect pecuniary interest, a conflict or potential conflict of interest or a direct or indirect material personal interest:

199.1 in a matter that has been considered or is about to be considered at a meeting, such a member or person shall, subject to By-Laws 204 and 205, not participate in the relevant discussion or resolution of any such interest or matter nor shall such a person be eligible to hold any office whilst any such interest exists; or

199.2 in a thing being done or about to be done by the Facility;

such a member or person shall as soon as possible after the relevant facts have come to the person's knowledge, disclose the nature of the interest at the meeting.

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

200.1 is a director or member or is in the employment of a specified company or other body;

200.2 is a partner, or is in the employment, of a specified person; or

200.3 has some other specified interest relating to a specified company or other body or a specified person;

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

201 A person who holds shares in Ramsay Health Care shall not be regarded as having a conflict of interest.

202 The committee shall cause particulars of any disclosure made under By-Laws 199 or 200 to be recorded and declared by the member or authorised person in writing on a pecuniary interest/conflict of interest/material interest declaration form.

203 The chairperson of the committee shall advise the CEO of any disclosure made pursuant to these By-Laws.

204 The CEO and chairperson of the committee shall make a determination in relation to the disclosure of an interest pursuant to this By-Law. Such determination may, but is not limited to, include making a determination that the member or person will not participate in the meeting when the matter is being considered or that the member or person will not be present while the matter is being considered at the meeting.

205 Subject to By-Law 200, for the purposes of this By-Law, the fact that a member of the MAC is a member of a particular discipline shall not be regarded as creating a direct or indirect pecuniary interest, a conflict or potential conflict of interest or a direct or indirect material personal interest if that committee member participates in the Accreditation of a Health Professional in the same discipline.

Statutory immunity for committees

206 Statutory immunity (otherwise referred to as qualified privilege) approval under the relevant State or Commonwealth legislation may only be sought for the Clinical Review Committee or a quality activity with the prior approval of the COO who shall consider the advice of the Clinical Governance Unit. No committee or sub-committee of the Facility shall seek any such statutory immunity or approval without the prior approval of the COO.

Schedule 1 - General Conditions of Accreditation

207 Accredited Health Professionals must:

207.1 comply with the provisions of the Act, the By-Laws and the rules, policies and procedures established by the Facility from time to time;

207.2 comply with codes of conduct and/or codes of behaviour adopted by the Facility and/or Ramsay Health Care from time to time;

207.3 comply with their authorised Scope of Clinical Practice;

207.4 maintain their professional registration with the relevant registration board, and furnish annually to the Facility when requested to do so documentary evidence of registration under the registration act for medical practitioners or health professionals in the State;

207.5 attend patients as often as is necessary to ensure high quality patient care and to comply with accepted professional standards;

207.6 document patient consent in accordance with the Facility's requirements and policy;

207.7 maintain adequate medical records in the format required by the Facility, sufficient to meet professional obligations for safe patient care and consistent with the accreditation or certification standards that apply to the Facility;

207.8 observe all reasonable requests made by the Facility with regard to personal conduct at the Facility and the provision of services at the Facility;

207.9 adhere to the generally accepted ethics of professional practice both in relation to colleagues and to patients;

207.10 observe the general conditions of clinical practice applicable to the Facility;

207.11 comply with Ramsay Health Care's policies regarding the presence in clinical areas of persons who are employed or engaged by medical equipment or device companies to promote and/or demonstrate the use of equipment and devices;

207.12 maintain with an approved professional indemnity organisation an adequate level of professional indemnity insurance covering the authorised scope of clinical practice and in accordance with standards approved from time to time by Ramsay Health Care;

207.13 furnish annually to the Facility documentary evidence of professional indemnity insurance including the level of cover; and advise the Facility immediately of any material changes to the level of or conditions associated with professional indemnity insurance;

207.14 be available or deputise an appropriately qualified Accredited Health Professional for emergency calls to the Accredited Health Professional's patients and participate in formal on call arrangements as required by the Facility;

207.15 participate in the Facility's clinical quality improvement program;

207.16 meet all reasonable requests to participate in the education and training of medical and other professional nursing and technical staff of the Facility and of students attending the Facility including facilitating the availability of patients for clinical teaching subject to:

207.16.1 any contrary instructions by either the treating practitioner or the nurse unit manager; and

207.16.2 informed consent being given by the patient;

207.17 attend regularly and when reasonably so required participate in such pertinent clinical meetings, seminars, lectures and other training programmes as may be organised and held at the Facility;

207.18 seek approval in accordance with these By-Laws to undertake any New Clinical Services, Procedures or Other Interventions;

207.19 not aid or facilitate the provision of care by persons who are not Accredited Health Professionals, including without limitation utilising surgical assistants who are not Accredited in accordance with these By-Laws or who are not in appropriate training positions at the Facility;

207.20 comply with any statutory regimes as required by any working with children legislation or legislation with similar objectives applicable to Health Professionals, including without limitation advising the Facility if they are charged with having committed or are convicted of a sex or violence offence;

207.21 authorise the Facility to conduct a criminal history check with the appropriate authorities at any time;

207.22 comply with all laws and Facility policies and procedures in relation to occupational health and safety, anti-discrimination, bullying and harassment; and

207.23 not represent in any way that they represent Ramsay Health Care or the Facility in any circumstances, including the use of Facility letterhead, unless with the express written permission of the CEO.

208 The admission of an Accredited Practitioner's patients to the Facility is subject to bed availability and the availability and adequacy of nursing or allied health staff or facilities at the relevant Facility given the type of treatment proposed to be conducted.

Schedule 2 - Conditions associated with Accreditation Classifications

209 Specialist Practitioners, General Practitioners, Staff Specialists and Dentists:

209.1 may admit and treat patients within their authorised Scope of Clinical Practice;

209.2 must assume responsibility for the clinical care of patients admitted under their care;

209.3 must participate in continuing education activities of the Facility; and

209.4 are full members of the Medical Council.

210 Surgical Assistants:

210.1 may not admit patients but may assist in theatre and visit patients in ward areas and examine clinical records but may not initiate or change treatment orders;

210.2 may have their Scope of Clinical Practice limited to a particular specialty or surgeon;

210.3 may participate in continuing education activities of the Facility; and

210.4 are not members of the Medical Council.

211 Consultant Emeritus;

211.1 may not admit patients unless they also are Accredited under a classification to which admission rights attach;

211.2 may consult to other practitioners on the care of their patients within their Scope of Clinical Practice;

211.3 may participate in continuing education activities of the Facility; and

211.4 are members of the Medical Council but have no voting rights unless they also have an Accreditation Classification to which voting rights attach.

212 Fellow Practitioners, Registrars and Career Medical Officers:

212.1 may not admit patients;

212.2 may treat patients under the supervision of an Accredited Medical Practitioner, or in the event of a medical emergency;

212.3 may participate in continuing medical education activities of the Facility; and

212.4 are not members of the Medical Council.

Reference

Australian Council for Safety and Quality in Health Care, (July 2004), Standard for Credentialing and Defining the Scope of Clinical Practice

Document History and Version Control Table:

Document Version	Date	Review Date	Document History / Revision	Document Author	Approved / Ratified	Endorsed
1.1	2004		Revision	Legal	RHC RMC	RHC Board
2.0	18/03/2008	Annually	Major Revision	RHC Credentialing Working Party & Legal	RHC RMC	RHC Board 18 Mar 2008

Amendments in this release:

Document Version	Date	SECTION	Amendment Summary
2.0	18/03/2008	**ALL**	**Total Revision**