



Exceptional People. Exceptional Care.

Mater Health Services By-Laws

Foreword

The Mater Hospitals are owned and operated by Mater Misericordiae Health Services Brisbane Limited ('Mater Health Services'), a company specifically established by the Brisbane Congregation of the Sisters of Mercy for the ownership and operation of their health ministry in Brisbane.

These By-Laws apply to the hospitals and any other health services established and operated by Mater Health Services. This means Mater Adult Hospital, Mater Children's Hospital, Mater Children's Private Hospital, Mater Mothers' Hospital, Mater Mothers' Private Hospital, Mater Private Hospital Brisbane, and Mater Private Hospital Redland.

The By-Laws describe medico administrative processes which apply to Health Practitioners providing clinical services at Mater Health Services. It is important to the Board that the application of the By-Laws is consistent with the Mission, Vision and Values of Mater Health Services and the Brisbane Congregation of the Sisters of Mercy.

The Board and Executive of Mater Health Services welcome the opportunity to work within the By-Laws for the advancement of quality patient care, clinical education and research in a safe and harmonious environment for all.

John McAuliffe
Chairman

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FLOWCHART**

PART A—INTERPRETATION AND GENERAL PROVISIONS

1. DEFINITIONS

In these By-Laws, words or expressions which are capitalised have the following meanings:

“ACCREDITATION” means the authorisation in writing by the Chief Executive Officer or an approved delegate for a Health Professional to treat patients at a Hospital with the Scope of Clinical Practice and in accordance with the conditions specified in that authorisation, and the processes including Credentialing that are described in these By-Laws leading to that authorisation.

“ACCREDITATION CLASSIFICATION” means one of the classifications in by-law 8(a).

“ACCREDITED PRACTITIONER” means a Medical Practitioner or Dentist authorised to treat patients at a Hospital within a designated Scope of Clinical Practice either as an employed practitioner or as an independent contractor.

“ADMITTING RIGHTS” means the rights of a Medical Practitioner or Dentist, who is principally responsible for the care, treatment, service coordination and discharge of patients, to book patients to use facilities owned and operated by Mater Health Services including areas such as wards, birth suites, procedural and operating theatres. It also includes the right to supervise fellow practitioners or registrars who are undertaking on call duties.

“ADVANCED SCOPE OF CLINICAL PRACTICE” has the meaning set out in by-law 10.

“ANAESTHETIC RIGHTS” means the rights of a Medical Practitioner to provide anaesthetic care and acute pain management in the operative/procedural environment as well as pre-anaesthetic assessments and post-anaesthetic follow-up at a Hospital.

“APPEALABLE DECISION” has the meaning set out in by-law 24(c).

“APPEALABLE DECISION NOTIFICATION” means, in relation to an Appealable Decision, a written notification of the decision, the reasons for the decision, and the internet address for these By-Laws.

“APPLICATION FORM” means the application form approved by Mater Health Services from time to time for use by a Health Practitioner to apply for Accreditation at any Hospital.

“BOARD” means the Board of the Company.

“BY LAWS” means these By-Laws.

“CHIEF EXECUTIVE OFFICER” or **“CEO”** is the senior management officer for Mater Health Services.

“CLINICAL DEPARTMENT” means a department or section of Accredited Practitioners in like sub specialties, the establishment of which has been approved by the Executive Director or equivalent of a Hospital.

“CODE OF ETHICAL STANDARDS” means the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia (2001), as amended or replaced.

“COMPANY” means Mater Misericordiae Health Services Brisbane Limited, ACN 096 708 922, the owner of Mater Health Services.

“CONSULTING RIGHTS” means the rights of a Medical Practitioner to provide care to a patient at a Hospital at the request of another Medical Practitioner who has admitted the patient and has primary responsibility for care.

“CREDENTIALLING” means the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of a health professional for the purpose of forming a view as to their competence, performance and professional suitability to provide safe, high quality health care services.

“CREDENTIALS” means the qualifications, professional training, clinical experience, Current Fitness, confidence held in that practitioner and training and experience in leadership, research, education, communication and teamwork that

contribute to a practitioner's competence, performance and professional suitability to provide safe, high quality health care services. For the purposes of these By-Laws, a practitioner's history of and current status with respect to professional registration, disciplinary actions, professional indemnity insurance, criminal record and compliance with the Code of Ethical Standards and Mater Health Services policy and procedure are also regarded as relevant to their credentials.

"CURRENT FITNESS" is the current fitness required of a practitioner to carry out the Scope of Clinical Practice sought or currently authorised. 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 the person's physical or mental capacity to practice their health profession and carry out the Scope of Clinical Practice sought or authorised. Habitual drunkenness or addiction to deleterious drugs is considered to be a physical or mental disorder which, if in place, would warrant an assessment of current fitness.

"DENTIST" has the same meaning as a health practitioner in the dental profession as defined in the National Law.

"DIRECTOR OF NURSING" howsoever termed means the person appointed by the Chief Executive Officer/Board to the senior nursing administration position at any Hospital or Mater Health Services and in the absence of that person, the person appointed to act in that position for the time being.

"EMERITUS CONSULTANT" means a Medical Practitioner or Dentist who has provided distinguished service to any Hospital or Mater Health Services, who has retired from active practice and is a member of the medical or dental profession of outstanding merit or extraordinary accomplishment, and who holds specialist registration (and not non practicing registration) with the Medical Board of Australia or Dental Board of Australia.

"EXECUTIVE DIRECTOR" means the person appointed as the senior executive or equivalent in any of the Hospitals by

the Board and in the absence of that person shall include the person appointed to act in that position for the time being.

"EXECUTIVE STAFF" means executive staff appointed in accordance with by-law 6.

"EXISTING ACCREDITATION" means an existing accreditation from another Hospital or a health organisation separate from Mater Health Services, including a Queensland Health Service District.

"GENERAL MEDICAL PRACTITIONER" means a Medical Practitioner who has been granted general medical registration.

"HEALTH DEPARTMENT" means the Department of the Government of Queensland with the responsibility for health in Queensland.

"HEALTH PRACTITIONER" means an individual who practices a health profession that is recognised under the Health Practitioner Regulation National Law Act 2009 or its successor.

"HOSPITAL" means any hospital or health service comprising part of Mater Health Services as relevant to the circumstances applicable in the context where used in these By-Laws.

"HOSPITALS NEEDS" refers to the extent to which a Hospital requires the provision of a specific clinical service, procedure or other intervention in order to provide a balanced mix of safe, high quality health care services that meet consumer and community needs and aspirations.

"HOSPITALS CAPABILITY" refers to the Hospitals ability to provide the facilities and clinical and non-clinical support services necessary for the provision of safe, high quality clinical services, procedures or other interventions.

"INTERMEDIATE RIGHTS" means the rights of a Medical Practitioner to treat privately or self insured patients using the facilities at a Hospital that are usually used for patients cared for under the terms of a contract with Queensland Health.

“MATER HEALTH SERVICES” means the combined Mater Hospitals being Mater Adult Hospital, Mater Children’s Hospital, Mater Children’s Private Hospital, Mater Mothers’ Hospital, Mater Mothers’ Private Hospital, Mater Private Hospital Brisbane, and Mater Private Hospital Redland and any other health service established by the Company.

“MEDICAL ADVISORY COMMITTEE” means any or all medical advisory committees established pursuant to these By-Laws as the context requires.

“MEDICAL PRACTITIONER” has the same meaning as a health practitioner in the medical profession as defined in the National Law.

“MISSION, VISION AND VALUES OF MATER HEALTH SERVICES” means the Mission, Vision and Values adopted by Mater Health Services, as amended from time to time.

“MUTUAL RECOGNITION ACCREDITATION” means Accreditation at a Hospital based on an Existing Accreditation, as provided for in by-law 28.

“NATIONAL LAW” means the Health Practitioner Regulation National Law Act 2009 (Qld).

“NATIONAL STATEMENT” means the National Health and Medical Research Council’s *National Statement on Ethical Conduct in Human Research (2007)*, as amended or replaced.

“NEW CLINICAL SERVICE, PROCEDURE OR OTHER INTERVENTION” means a clinical service, procedure or intervention that is new to the relevant Hospital, and requires more than incremental change in the way in which health care services are delivered at the Hospital. It may have been established in other organisational settings and be deemed by a responsible body of medical opinion to be of benefit to patients, or it may remain experimental, and therefore subject to review by a properly constituted human research ethics committee or clinical ethics committee (as appropriate).

“PROCEDURAL RADIOLOGY OR PATHOLOGY RIGHTS” means the rights of a Medical Practitioner to undertake a procedure to provide diagnostic material or treatment at a Hospital at the request of the primary or admitting medical practitioner.

“SCOPE OF CLINICAL PRACTICE” means the extent of an individual Health Practitioners, Medical Practitioner’s or Dentist’s clinical practice within a particular Hospital based on the individual’s credentials, competence, performance and professional suitability, and the Hospital’s Needs and Hospital’s Capabilities—sometimes called ‘clinical privileges’.

“SPECIALIST MEDICAL PRACTITIONER” means a Medical Practitioner who has been recognised as a specialist in their nominated category, for the purpose of the Health Insurance Act 1973 (Cth) and has been granted specialist medical registration in a specialty including the specialty of General Practice.

“SPECIALTY” means a specialty recognised by the Medical Board of Australia or Dental Board of Australia, as the case may be, and may include more specific specialist titles recognised by those boards.

“STAFF SPECIALIST” means a Specialist Medical Practitioner appointed to and employed by or seconded to a Hospital.

“SURGICAL ASSISTANT” means a Health Practitioner who assists an Accredited Practitioner in the operating theatre.

“SURGICAL ASSISTING RIGHTS” means the rights of a Medical Practitioner at a Hospital to assist an Accredited Medical Practitioner who has surgical/procedural Admitting Rights and does not include rights to take primary responsibility for patient care.

2. INTERPRETATION

In these By-Laws:

- (a) headings are inserted for convenience only and do not affect the interpretation of these By-Laws;
- (b) 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;
- (c) a reference to a clause, by law, part, schedule or attachment is a reference to a clause, by law, part, schedule or attachment of or to these By-Laws;
- (d) 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;
- (e) 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;
- (f) a reference to the word "include" or "including" is to be construed without limitation;
- (g) where there is use of the title chairperson, the incumbent of that position for the time being may choose to use whichever designation that person so wishes;
- (h) any annexures form part of these By-Laws.

3. THE BOARD

The Board has the authority on behalf of the Company to make by-laws, rules and policies for the operation of Mater Health Services as it may deem necessary from time to time.

4. CHIEF EXECUTIVE OFFICER

The Chief Executive Officer is:

- (a) the officer responsible for the conduct of the Company;
- (b) the spokesperson and, other than in exceptional circumstances, the channel for all formal communications to and from the Company;
- (c) responsible for the management of the Company and its staff and resources including the provision of patient care to acceptable standards, in accordance with the policies and directives of the Board; and
- (d) responsible for ensuring compliance with all laws, these By-Laws and all other legal requirements by the Company.

5. EXECUTIVE DIRECTOR

The Executive Director:

- (a) is the officer at the Hospital to whom all staff, through their respective department heads, are responsible;
- (b) is the spokesperson and, other than in exceptional circumstances, the channel for all formal communications to and from the Hospital;
- (c) is responsible for the management of the Hospital and its staff and resources including the provision of patient care to acceptable standards, in accordance with the policies and directives of the Board;
- (d) may establish Clinical Departments of Accredited Practitioners to facilitate achievement of the Hospital's objectives; and
- (e) is responsible for ensuring compliance with all laws, these By-Laws and all other legal requirements at a Hospital.

6. EXECUTIVE STAFF

The Board or delegate may appoint any executive staff members they deem appropriate for any Hospital or Mater Health Services including determining the role of such an appointment.

7. HOSPITAL OR MATER HEALTH SERVICES COMMITTEES

- (a) The Board must establish committees covering the functions of:
 - (i) medical advisory;
 - (ii) credentialling; and
 - (iii) any other committees that any Hospital in consultation with the Board determines are necessary from time to time.
- (b) All committees are to have a membership, chairperson, secretary, terms of reference and meeting procedure determined by Mater Health Services following approval by the Board.
- (c) Initially, Medical Advisory Committees and Credentialling Committees will be convened for each of:
 - (i) Mater Mothers' Public and Private Hospitals;
 - (ii) Mater Children's Public and Private Hospitals;
 - (iii) Mater Adult Hospital;
 - (iv) Mater Private Hospital Brisbane; and Mater Private Hospital Redland.
- (d) Hospitals may merge the committees and /or functions, established by by-law 7(a), across Hospitals, with the agreement of the Chief Executive Officer.

PART B—ACCREDITATION OF MEDICAL PRACTITIONERS AND DENTISTS

8. ACCREDITATION CLASSIFICATIONS

- (a) Each Accredited Practitioner will be designated one or more of the following Accreditation Classifications with respect to each Hospital to which they are accredited:
 - (i) General Medical Practitioner;
 - (ii) Specialist Medical Practitioner;
 - (iii) Dentist – general or specialist;
 - (iv) Emeritus Consultant; and
 - (v) Surgical Assistant.
- (b) The following Medical Practitioners and Dentists will not be accredited:
 - (i) Resident medical officers (interns, house officers , registrars, fellows), who will have a supervisor who is an Accredited Practitioner;
 - (ii) Medical Practitioners or Dentists undertaking research that does not involve undertaking or influencing clinical care;
 - (iii) Eminent visitors;
 - (iv) Clinical observers;
 - (v) Clinical visitors, observers or supervised practice;
 - (vi) Medical observers; and
 - (vii) Medical practitioners undertaking examinations.
- (c) A Medical Practitioner or Dentist to whom the requirements for Accreditation stated in these By-Laws apply, whether they are a Mater Health Services employee or an independent contractor, may treat patients at a Hospital only if they have been accredited Scope of Clinical Practice to do so and only in accordance with the terms of their Scope of Clinical Practice.

9. SCOPE OF CLINICAL PRACTICE

- (a) Each Medical Practitioner or Dentist who applies for Accreditation must apply for approval of a Scope of Clinical Practice defined by:
 - (i) Specialty;
 - (ii) area of specialisation (includes specific procedures where applicable);
 - (iii) Hospital where clinical activity will be undertaken; and
 - (iv) clinical practice rights.
- (b) The categories of clinical practice rights are:
 - (i) Admitting Rights;
 - (ii) Consulting Rights;
 - (iii) Anaesthetic Rights;
 - (iv) Surgical Assisting Rights;
 - (v) Procedural Radiology or Pathology Rights; and
 - (vi) Intermediate Rights.
- (c) Accredited Practitioners with the following Accreditation Classifications are not entitled to have Admitting Rights to any Hospital:
 - (i) Emeritus Consultant; and
 - (ii) Surgical Assistant.
- (d) An Emeritus Consultant is eligible to have the following categories of clinical practice rights listed in by-law 9(b)
 - (i) Consulting Rights; and
 - (ii) Surgical Assisting Rights.

10. ADVANCED SCOPE OF CLINICAL PRACTICE

- (a) Where an Accredited Practitioner's Scope of Clinical Practice is beyond that which is normally considered standard at the time of completion of a specialist fellowship or there has been more than six years since the completion of a general fellowship, they may be credentialed and approved for an Advanced Scope of

Clinical Practice to identify and confirm specific required additional training and experience in a specific area of clinical activity.

- (b) Areas where Credentialling for an Advanced Scope of Clinical Practice will be undertaken will be determined by the Credentialling Committee and will be informed by the process of introduction of New Clinical Services, Procedures and Other Interventions and by current policies or guidelines published by the professional colleges, associations and societies.

TERM OF ACCREDITATION OF ACCREDITED PRACTITIONERS

- (b) Initial Accreditation—other than temporary or emergency Accreditation—is for a maximum of 12 months.
- (c) Accreditation after initial Accreditation is for a maximum of five years.
- (d) The term of temporary Accreditation is as provided in by-law 17(d).
- (e) The term of emergency Accreditation is as provided in by-law 18(d).

11. APPLICATION FORM

The Chief Executive Officer or delegate must provide each Medical Practitioner or Dentist seeking Accreditation with an Application Form and a copy of these By-Laws.

12. CONFIDENTIALITY

The proceedings involved in Accreditation of a Medical Practitioner or Dentist are confidential and not to be disclosed outside the particular forum concerned. These confidentiality obligations also apply to any confidential information and to any committee or sub-committee of a Hospital and/or Mater Health Services.

13. PROCESS OF APPLICATION FOR ACCREDITATION OR RE-ACCREDITATION

A Medical Practitioner or Dentist, whether they are a Mater Health Services employee or an independent contractor, seeking Accreditation or re-Accreditation to practice in a Hospital must complete an Application Form and provide the form to the Chief Executive Officer or delegate.

14. CONSIDERATION OF APPLICATION

- (a) Following receipt of a completed Application Form:
 - (i) the Chief Executive Officer or delegate, who should normally be the relevant hospital Executive Director, must give the form to the relevant Credentialling Committee(s);
 - (ii) the Credentialling Committee(s) must review the application, satisfy itself as to the Applicant's Credentials, taking into account current Scope of Clinical Practice (if any) and the Hospital's Needs and Hospitals Capabilities, and make recommendations as to the practitioner's Accreditation and Scope of Clinical Practice;
 - (iii) following a determination of its recommendation, the Credentialling Committee must forward its recommendation to the Chief Executive Officer or delegate;
 - (iv) the Chief Executive Officer or delegate must submit the Credentialling Committee's recommendation to the Board, together with any advice the Chief Executive Officer or delegate may have;
 - (v) the Board or its delegate must make a final determination as to the application.
- (b) The procedure on receipt of a completed Application Form in by-law 15(a) does not apply to any applicant who has had an Accreditation terminated or suspended on any previous occasion, whether at a Hospital or any other health facility. In these circumstances, the Chief Executive Officer must consider these applications

and must, in his or her discretion, refer the application to the relevant Credentialling Committee/s or make an appropriate recommendation directly to the Board. The Board must make a final determination as to any application of this kind.

15. NOTIFICATION OF DECISION

Within 14 days of arriving at its decision, the Board's delegate must notify the applicant in writing of the decision or, if it is an Appealable Decision, the Board's delegate must make an Appealable Decision Notification.

16. TEMPORARY ACCREDITATION

- (a) The Chief Executive Officer, Executive Director or delegate or either may authorise temporary Accreditation of a Medical Practitioner or Dentist, including an Accreditation Classification and authorised Scope of Clinical Practice, after consultation with the chairperson of the respective Credentialling Committee and/or head of the appropriate Clinical Department if the chairperson of the Credentialling Committee is unavailable, before an application for Accreditation has been determined.
- (b) A Medical Practitioner or Dentist seeking temporary Accreditation must submit an Application Form to the Chief Executive Officer or delegate, along with all required supporting documentation including curriculum vitae with education, training and employment history.
- (c) At a minimum, credentialling for temporary Accreditation requires verification of identity through inspection of relevant documents, verification as soon as possible with the Medical Board of Australia of the practitioner's registration history, good standing and past record of professional sanctions or disciplinary actions, and confirmation as soon as practicable by at least one professional referee of the practitioner's competence and good standing. Credentialling for temporary Accreditation may also include confirmation of claimed employment history or good standing through immediate contact with the practitioner's most recent place of appointment.

- (d) A temporary Accreditation remains in force until the earlier of a final determination of the application or a specified date or event or four months.
- (e) The Executive Director or delegate may extend the term of a temporary Accreditation for a maximum of four months.
- (f) A temporary Accreditation may be terminated at any time, for any reason, with no right of appeal.

17. EMERGENCY ACCREDITATION

- (a) Emergency Accreditation may be made in an urgent or counter-disaster situation to ensure patient safety and care is not compromised in the absence of a normally available practitioner's services.
- (b) The Chief Executive Officer, Executive Director or delegate may authorise emergency Accreditation of a Medical Practitioner or Dentist, including an Accreditation Classification and authorised Scope of Clinical Practice.
- (c) At a minimum, credentialling for emergency Accreditation requires verification of identity through inspection of relevant documents, verification as soon as possible with the Medical Board of Australia of the practitioner's registration history, good standing and past record of professional sanctions or disciplinary actions, and confirmation as soon as practicable by at least one professional referee of the practitioner's competence and good standing. Credentialling for emergency Accreditation may also include confirmation of claimed employment history or good standing through immediate contact with the practitioner's most recent place of appointment.
- (d) Emergency Accreditation is for 72 hours or until the next working day of Mater Health Services' administration, to allow the applicant time to complete an Application Form to initiate the normal Accreditation process as soon as reasonably practicable.
- (e) Where applicable, the Medical Practitioner or Dentist who provides emergency care must advise a patient's own practitioner at the earliest possible time of the emergency and the actions taken in regard to the patient.

18. RESIGNATION OR EXTENDED ABSENCE OF AN ACCREDITED PRACTITIONER

- (a) An Accredited Practitioner who intends to cease treating patients at a Hospital either indefinitely or for an extended period must notify their intention to the Executive Director. Accreditation will be taken to be relinquished from the date specified in the notification.
- (b) An Accredited Practitioner in this situation must, whenever practicable, advise the Executive Director before the end of his or her normal patient bookings and clinical activities and must ensure that upon ending clinical activities, any remaining patients are either discharged or referred with appropriate consent to the care of another accredited practitioner with the same scope of practice to ensure continuous patient care.
- (c) It is the responsibility of the non-employee Accredited Practitioner to notify their own patients and any known carers or legal guardians of their patients of any proposed changes to their care arrangements.

19. TERMS AND CONDITIONS OF ACCREDITATION

The Accreditation of a Medical Practitioner or Dentist is conditional on the practitioner:

- (a) complying with general law, legislation and the by-laws, rules and policies and procedures of the Hospital and Mater Health Services as varied from time to time;
- (b) conducting themselves in accordance with the Mission, Vision and Values and Code of Conduct of Mater Health Services;
- (c) attending patients subject to any conditions imposed by the Board and in accordance with the Code of Ethical Standards;
- (d) complying with their Scope of Clinical Practice;

- (e) maintaining their professional registration with the relevant registration board, and providing documentary evidence of registration to the Hospital annually when requested;
- (f) attending patients as often as is necessary to ensure high quality patient care and to comply with accepted professional and healthcare standards;
- (g) attending patients in an emergency situation as may be reasonably requested from time to time by an Executive or Clinical Director of a Hospital;
- (h) documenting patient consent in accordance with the Hospital's requirements and policy;
- (i) maintaining adequate hospital medical records in the format required by the Hospital, and sufficient to meet obligations for safe patient care, and recording any other data reasonably required by the Hospital or Mater Health Services to enable it to collect revenue;
- (j) observing all reasonable requests made by the Hospital or Mater Health Services with regard to personal conduct in the Hospital or Mater Health Services and with regard to the provision of services within the Hospital or Mater Health Services;
- (k) adhering to the generally accepted ethics of professional practice including, wherever possible, avoiding providing medical care to anyone with whom the practitioner has a close personal relationship;
- (l) maintaining appropriate professional indemnity insurance consistent with the employment status and Scope of Clinical Practice sought or held and at a level approved by Mater Health Services;
- (m) where appropriate, annually providing the Hospital or Mater Health Services with evidence of professional indemnity insurance including the level of cover, and advising the Hospital immediately of any material changes to the level or conditions associated with their professional indemnity insurance;
- (n) advising the Hospital or Mater Health Services if they are the subject of an investigation by the Health Quality Complaints Commission, the relevant registration board or the Coroner; or if they have an adverse finding made by the Health Quality Complaints Commission or the relevant registration board; or if their professional registration is revoked or amended; or if their authorised scope of clinical practice is changed, or their right to practice is denied, suspended, terminated or withdrawn (other than for Hospital Need and/or Hospital Capability reasons) in any other hospital or day procedure centre, within two days of any of these events;
- (o) advising the Hospital or Mater Health Services if they are the subject of any criminal investigation or conviction, including for a sex or violence offence, within two days of any of these events, and providing authority to the Hospital to conduct a criminal history check with the appropriate authorities at any time;
- (p) participating in any clinical quality assurance, quality improvement and clinical risk management programs approved by the Medical Advisory Committee;
- (q) participating in formal on call arrangements as required by the Hospital or Mater Health Services, following advice from the relevant Medical Advisory Committee to the Executive Director or Chief Executive Officer on the need for on call rosters in disciplines necessary for safe patient care in any Hospital;
- (r) excepting Mater Health Services' employees, not representing in any way that they represent the Company or any Hospital or Mater Health Services in any circumstances, including the use of Hospital or Mater Health Services letterhead, unless with the express written permission of the Chief Executive Officer;
- (s) being available, or deputising an appropriately qualified Accredited Practitioner, for emergency call to the Accredited Practitioner's patients;
- (t) participating in reasonable education activities of the staff as required particularly in relation to any junior medical staff; and

- (u) seeking the approval of the relevant Credentialling Committee and, where relevant, a human research ethics committee in regard to any New Clinical Service, Procedure or Other Intervention to treat patients.

20. REQUEST FOR VARIATION OF SCOPE OF CLINICAL PRACTICE

- (a) Any Accredited Practitioner, at any time, may request a variation to their Scope of Clinical Practice.
- (b) The process for variation for Scope of Clinical Practice is the same as for an initial determination of the Scope of Clinical Practice. The Chief Executive Officer, Executive Director or delegate of either may waive the requirement to submit evidence of specific Credentials if satisfied that there has been no change to those Credentials since they were last determined.

21. SUSPENSION OR TERMINATION

- (a) The Board or the Chief Executive Officer may suspend, and the Board may terminate, the Accreditation of an Accredited Practitioner, if:
 - (i) the relevant Hospital cannot or elects not to provide the facilities or support services necessary for safe service provision, or the Hospital no longer needs the clinical services, procedures or other interventions which have previously been included in the Accredited Practitioner's Scope of Clinical Practice and, in either case, the practitioner's Scope of Clinical Practice cannot be altered by agreement;
 - (ii) the practitioner ceases to be registered or to hold professional indemnity insurance that is at or above the level required by Mater Health Services or is otherwise unacceptable to Mater Health Services;
 - (iii) the practitioner becomes incapable of performing his/her duties for a continuous period of six months;
 - (iv) the Board does not consider that the Accredited Practitioner has the appropriate Current Fitness to retain their Scope of Clinical Practice or the

Board does not have confidence in the continued Accreditation of the practitioner;

- (v) the practitioner fails to observe the terms and conditions of their Accreditation, including these By-Laws or the policies and procedures of the relevant Hospital;
 - (vi) the practitioner is found guilty of professional misconduct or unprofessional conduct by the relevant Board;
 - (vii) the practitioner engages in behaviour or conduct that seriously contravenes the Mission, Vision and Values of Mater Health Services, or the Code of Ethical Standards;
 - (viii) a review of the practitioner has been conducted under by-law 23 and, after taking into consideration the report of that review, the Board does not have confidence to continue Accreditation of the practitioner;
 - (ix) the practitioner is subject to a criminal investigation about a serious matter which, if established, could affect their ability to perform their Scope of Clinical Practice or other material duties safely and competently and with the confidence of Mater Health Services and the broader community; or
 - (x) the practitioner has been convicted of a serious crime which could affect their ability to perform their Scope of Clinical Practice or other material duties safely or competently and with the confidence of Mater Health Services and the broader community.
- (b) An Accredited Practitioner's Accreditation may be terminated as otherwise provided in these By-Laws.
 - (c) Where a decision to suspend or terminate an Accreditation is also an Appealable Decision, the Board must ensure that the practitioner receives an Appealable Decision Notification.
 - (d) An Accredited Practitioner may resign their Accreditation

after the expiry of one month after the giving of notice to the Hospital or Mater Health Services, unless agreed otherwise by the Board. If an Accredited Practitioner is employed by Mater Health Services then the notice period in their terms of employment applies instead.

22. REVIEW OF ACCREDITATION AND/OR SCOPE OF CLINICAL PRACTICE

- (a) At any time, the Board may commission a review, including setting the terms of reference, of an Accredited Practitioner's Accreditation and/or Scope of Clinical Practice. The review may include an assessment of any of the practitioner's compliance with their terms and conditions under by-law 20, Current Fitness, confidence held in that practitioner and a Hospital's Needs and Hospitals Capabilities:
 - (i) through the Chief Executive Officer, by any relevant Credentialling Committee(s), following normal Credentialling processes;
 - (ii) through a combined process where a Practitioner holds accreditation at multiple Hospitals
 - (iii) by an independent person or persons chosen by the Board or its delegate;
 - (iv) by the Board itself or its delegate; or
 - (v) by the Clinical Competencies Framework adopted from time to time by the Company.
- (b) The Chief Executive Officer, following consultation with the chairperson of the relevant Credentialling Committee/s, may alter or suspend the Scope of Clinical Practice of an Accredited Practitioner at the relevant Hospitals pending a review.
- (c) The Accredited Practitioner who is the subject of a review must:
 - (i) be informed in writing of the proposed review, including reasonable particulars about any issues of concern;

- (ii) be provided with an opportunity to make a submission to the review; and
 - (iii) cooperate with reviewers, including providing information reasonably required to inform the review.
- (d) The findings and recommendations of the review must be made to the Board which must make a final determination in relation to the matter, subject to by-law 24.
- (e) The Chief Executive Officer must implement the decision immediately and, if applicable, must make an Appealable Decision Notification.

23. AVAILABILITY OF A RIGHT OF APPEAL

- (a) Subject to by-law 24(b), an Accredited Practitioner has the rights of appeal under by-law 25 in relation to a decision regarding their Accreditation, including a decision:
 - (i) regarding an application for Accreditation or re-Accreditation;
 - (ii) regarding suspension or termination of their Accreditation; or
 - (iii) variation of their Scope of Clinical Practice.
- (b) The availability of a right of appeal under these By-Laws is limited as follows:
 - (i) an Accredited Practitioner with a temporary or emergency Accreditation has no right of appeal in relation to decisions regarding their Scope of Clinical Practice or Accreditation, including a decision not to authorise an Accreditation or re-Accreditation or to suspend or terminate an Accreditation; and
 - (ii) there is no right of appeal in respect of a decision regarding an application for initial Accreditation or for Accreditation immediately following initial Accreditation, including a decision to authorise or not to authorise Accreditation in either case.
- (c) A decision that entitles an Accredited Practitioner

to a right of appeal under this by-law 24 is called an “Appealable Decision”.

24. APPEAL PROCEDURE

- (a) An Accredited Practitioner subject to an Appealable Decision must notify the Chief Executive Officer of their appeal within 14 days of receiving an Appealable Decision Notification. The appellant must state whether they are seeking the Board’s approval to be accompanied by a support person at any in person appearance during the appeal procedure.
- (b) The Board must nominate a committee (“Appeal Committee”) to hear the appeal. The Appeal Committee must comprise:
 - (i) a nominee of the Board, who will also be the chairperson of the Appeal Committee;
 - (ii) a nominee of the relevant Credentialling Committee(s); and
 - (iii) a nominee of the appropriate professional college or association of the appellant;
 - (iv) at least one practitioner who practises in the field relevant to the scope of clinical practice being reviewed, appointed by the Chief Executive Officer and Executive Director; and
 - (v) a nominee, who is a practitioner, of the person whose Accreditation or Scope of Clinical Practice is the subject of the appeal.
- (c) The appellant must be provided with appropriate notice by the Appeal Committee and have the opportunity to make a submission to the Appeal Committee.
- (d) The appellant must provide written submissions to the Appeal Committee. The Appeal Committee also has the discretion to permit the appellant to present to it in person.
- (e) At any meeting of the Appeal Committee attended by the appellant, the appellant may be accompanied by a support person, who may be a barrister or solicitor

or other person, if the Board or delegate has approved the support person’s attendance. At a meeting, the support person’s role may include providing advice to the appellant but not representing the appellant.

- (f) The chairperson of the Appeal Committee must determine any question of procedure for the Appeal Committee, including co-option of non-voting members.
- (g) The Appeal Committee must make a written recommendation to the Board.
- (h) The Board must make a final and binding decision on the appeal, taking into consideration the recommendation of the Appeal Committee. The Board must notify the appellant of its decision in writing.

25. ACCREDITATION DURING PERIOD OR REVIEW OR APPEAL

- (a) During the period of review and or appeal a practitioners accreditation may be suspended or their scope of practice limited.
- (b) The decision to suspend or limit scope of practice will be made by the Chief Executive Officer and will be communicated to the practitioner in writing.

PART C—MUTUAL RECOGNITION

26. ELIGIBILITY FOR MUTUAL RECOGNITION

A Hospital may use Mutual Recognition Accreditation of a Medical Practitioner or Dentist if:

- (a) the practitioner has an Existing Accreditation, and
- (b) in the case of an accreditation from a health organisation separate from Mater Health Services:
 - (i) the practitioner is employed to undertake clinical activity at that organisation; and
 - (ii) the Credentialling and Scope of Practice policies and procedures of that health organisation are externally audited to ensure compliance with the Australian Council for Safety and Quality in Health Care’s *National Standard for Credentialling and Defining the*

Scope of Clinical Practice for Medical Practitioners, for Use in Public and Private Hospitals (2004), as amended or replaced.

27. CIRCUMSTANCES FOR MUTUAL RECOGNITION ACCREDITATION

Circumstances in which a Medical Practitioner may receive Mutual Recognition Accreditation include where the practitioner:

- (a) has Accreditation at any one Hospital and is seeking Accreditation at any other Hospital;
- (b) is working on a colocated campus with a (Mater Health Services) Hospital and a Queensland Health Service District facility;
- (c) is employed and accredited by a Queensland Health Service District and seeks to provide clinical services at any Hospital including temporary services and participation in a Brisbane wide on-call roster; and
- (d) has accreditation from a separate health organisation other than a Queensland Health Service District, such as an organisation providing radiology and pathology services.

28. PROCESS FOR MUTUAL RECOGNITION ACCREDITATION

- (a) To apply for Mutual Recognition Accreditation, a Medical Practitioner must complete the relevant application form;
- (b) Where a Medical Practitioner's Existing Accreditation is with a Queensland Health facility, the practitioner must provide a record of their Existing Accreditation;
- (c) The relevant Credentialling Committee must consider the practitioner's Credentials, taking into account their Scope of Clinical Practice for their Existing Accreditation and the Hospital's Needs and Capabilities;
- (d) The relevant Credentialling Committee must make a recommendation concerning the appropriate Scope of Clinical Practice and/or the Accreditation for the

practitioner to the Board, through the Chief Executive Officer, for a decision by the Board.

29. RE-ACCREDITATION UNDER MUTUAL RECOGNITION PROCESS

- (a) The review date for a Medical Practitioner with Mutual Recognition Accreditation must be no later than the review date of that practitioner's Existing Accreditation.
- (b) The Credentialling Committee of a Hospital may authorise the subsequent Accreditation of a Medical Practitioner with Mutual Recognition Accreditation at that Hospital, if that practitioner has received subsequent accreditation from the separate health organisation from which they have Existing Accreditation.

PART D—MEDICAL ADVISORY COMMITTEES AND CREDENTIALLING COMMITTEES

30. COMPOSITION OF MEDICAL ADVISORY COMMITTEES

- (a) Subject to by-law 7(c), for each Hospital mentioned in by-law 7(d), there must be established and maintained a separate Medical Advisory Committee, whose members, including a chairperson and deputy chairperson, will be elected for a two year term from an electorate of all Accredited Practitioners at that Hospital.
- (b) The membership of a Medical Advisory Committee will comprise:
 - (i) at least five Accredited Practitioners including at least one from each of the major specialty groups of the Hospital, whose eligibility is determined in accordance with by-law 30(c);
 - (ii) the Executive Director or their delegate and
 - (iii) the Director of Nursing.
- (c) An Accredited Practitioner (other than a Consultant Specialist/General Practitioner or Emeritus

Consultant) is eligible for election as a member of a Medical Advisory Committee under by-law 30(b) (i) if they regularly work at, attend or report to the Hospital. Regularity is determined at the discretion of the Chief Executive Officer.

- (d) Any member of a Medical Advisory Committee may appoint an alternate, who must themselves be eligible for membership of the Medical Advisory Committee, who will also have voting rights. Any appointment of an alternate requires the approval of the chairperson of the committee.
- (e) Any member of a Medical Advisory Committee may resign as a member by giving at least one month's notice in writing of their intention to resign to the Executive Director.
- (f) A Medical Advisory Committee may co-opt the services of any other person if it considers this necessary however that person will have no voting rights at any meeting of the Medical Advisory Committee or any sub-committee.

31. ROLE OF MEDICAL ADVISORY COMMITTEE

- (a) The Medical Advisory Committee provides advice to the Chief Executive Officer or delegate.
- (b) The roles of the Medical Advisory Committee are to:
 - (i) be the formal organisational structure through which the views of the Accredited Practitioners of the Hospital are formulated and communicated;
 - (ii) provide a means by which Accredited Practitioners can participate in the policy making and planning processes of the Hospital;
 - (iii) advise on a continuing education program for Accredited Practitioners or junior medical staff where appropriate;
 - (iv) advise the Chief Executive Officer of appropriate policies regarding the clinical organisation of the Hospital;

- (v) assist in identifying health needs of the community and advise the Chief Executive Officer on appropriate services which may be required to meet these needs;
 - (vi) participate in the planning, development and implementation of quality programs of the Hospital;
 - (vii) endeavour to ensure that the delivery of patient care in the Hospital is maintained at an optimal level of quality and efficiency given the resources locally available;
 - (viii) ensure that a formal mechanism for review of clinical outcomes and management is established and ensure Accredited Practitioners engage in that mechanism in accordance with these By-Laws; and
 - (ix) where there is no Credentialling Committee for a particular Hospital, perform the role of the Credentialling Committee for that Hospital.
- (c) No office bearer of the Medical Advisory Committee nor any of its members or sub-committees may represent in any way that they represent the Company, Mater Health Services or the Hospital in any circumstances unless with the express written permission of the Chief Executive Officer.

32. MEETINGS OF MEDICAL ADVISORY COMMITTEE

- (a) Ordinary meetings of a Medical Advisory Committee shall be held not less than six times a year at a time and place to be determined by the chairperson in consultation with the Chief Executive Officer or delegate provided that at least 14 days notice shall be given of every ordinary meeting.
- (b) A special meeting of a Medical Advisory Committee may be called by the chairperson of the Medical Advisory Committee, with members being given at least seven days notice of the meeting.
- (c) Notice of a special meeting must specify the business to be considered and, in the absence of unanimous agreement of members of the Medical Advisory

Committee to the contrary, no business of which notice has not been given may be considered at the meeting.

- (d) In an emergency, the Chief Executive Officer or the Executive Director may act without advice from the Medical Advisory Committee in circumstances where that advice ordinarily would be required. The Medical Advisory Committee must consider the issue at a subsequent meeting.

33. PROCEEDINGS OF MEDICAL ADVISORY COMMITTEE

- (a) Entitlement to vote at meetings of a Medical Advisory Committee is given under these By-Laws to the Accredited Practitioner members of the Committee.
- (b) The following quorum requirements apply:
 - (i) quorum will be a simple majority of members of a Medical Advisory Committee; and
 - (ii) a decision may be made by a Medical Advisory Committee without a meeting if all committee members sign their consent on a document (which may have counterparts) which states the decision or communicates by electronic means in a manner acceptable to the Chair.
- (c) All questions, except as otherwise provided in these By-Laws, must be decided by a show of hands, or where demanded by a member entitled to vote, a ballot. The chairperson of the Medical Advisory Committee will have a deliberative and, in the case of equal votes, a casting vote.
- (d) The Medical Advisory Committee may hold any meeting by electronic means as long as participants can be heard and can hear even if they are not in the same place. The requirements of these By-Laws still apply to a meeting of this kind.
- (e) Minutes of all meetings of a Medical Advisory Committee must be recorded by the Chief Executive Officer or delegate.

- (f) Minutes must be distributed to all those entitled to attend meetings of a Medical Advisory Committee before the next meeting.
- (g) No business may be considered at a meeting of a Medical Advisory Committee until the minutes of the previous meeting have been confirmed or otherwise disposed of. No discussion of the minutes is permitted except as to their accuracy.
- (h) Minutes of a meeting must be confirmed by resolution and signed by the chairperson at the next meeting. Minutes confirmed and signed in that way will be taken as evidence of proceedings of that meeting.

34. COMPOSITION OF CREDENTIALLING COMMITTEES

- (a) Subject to by-law 7(a), for each Hospital mentioned in by-law 7(d), there must be established and maintained a separate Credentialling Committee, whose members are elected for a two year term from the body of all Accredited Practitioners at that Hospital.
- (b) The membership of a Credentialling Committee will comprise:
 - (i) at least five Accredited Practitioners including at least one from each of the major specialty groups of the Hospital;
 - (ii) the Chief Executive Officer, the Executive Director or the delegate of either; and
 - (iii) if a non-employee is under consideration, a nominee of the relevant Specialty for the practitioner under consideration may be co-opted.
- (c) The provisions relating to composition of the Medical Advisory Committee in by-laws 33(c) to (f) apply to the Credentialling Committee as well, after substituting "Credentialling Committee" for "Medical Advisory Committee".

35. ROLE OF CREDENTIALLING COMMITTEES

- (a) The Credentialling Committee is the committee that provides advice on Accreditation to the Chief Executive Officer as representative of the Board.
- (b) The roles of the Credentialling Committee are to:
 - (i) ensure that its members are aware of their obligations to act fairly and without bias and to avoid conflicts of interest;
 - (ii) develop and review criteria and monitor the effectiveness of a program of Credentialling and defining the Scope of Clinical Practice, if requested by the Board;
 - (iii) in response to applications for Accreditation or re-Accreditation referred to the Credentialling Committee, and based on an investigation and assessment of the practitioner's Credentials, taking into account current Scope of Clinical Practice (if any) and the Hospital's Needs and Capabilities, make a recommendation concerning the appropriate Scope of Clinical Practice and/or the Accreditation for the practitioner to the Board, through the Chief Executive Officer;
 - (iv) in response to a request for a variation of their authorised Scope of Clinical Practice by an Accredited Practitioner, review the Scope of Clinical Practice and make a recommendation concerning the appropriate Scope of Clinical Practice for the Practitioner to the Board, through the Chief Executive Officer;
 - (v) if directed by the Board or Chief Executive Officer (that is, other than in response to applications for Accreditation or re-Accreditation or variation of current Scope of Clinical Practice), and based on a review of the Practitioner's Credentials, which may include an assessment of any of Current Fitness, confidence held in that practitioner and a Hospital's Needs and Capabilities, make a recommendation concerning the continuation, amendment, suspension

- or termination of the Scope of Clinical Practice and/or Accreditation of the Practitioner to the Board; and
- (vi) review any proposed New Clinical Services, Procedures and Other Interventions, assessing the Hospital's Needs and Capabilities and other matters which are considered relevant, and make a recommendation on the amendment of the Scope of Clinical Practice of an Accredited Practitioner.
- (c) The Credentialling Committee may request an 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 Credentials and/or submit written material in support of their requested Scope of Clinical Practice and/or present in person to the committee.
- (d) The Credentialling 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 for a designated period.

36. MEETINGS AND PROCEDURES OF CREDENTIALLING COMMITTEES

The requirements for meetings and proceedings for the Credentialling Committee are the same as those provided for Medical Advisory Committees in by-laws 32 and 33, after substituting "Credentialling Committee" for "Medical Advisory Committee".

PART E—ACCREDITATION OF OTHER HEALTH PRACTITIONERS

37. ELIGIBILITY

Part E of the By-Laws shall apply to non-Medical non Dental (Other) Health Practitioners who are not employees of Mater Health Services

38. PROCESS OF APPLICATION FOR ACCREDITATION OR REACCREDITATION

- (a) An Other Health Practitioner must complete an application form and provide the form to the Chief Executive Officer or delegate. As part of the application, an applicant must provide evidence of indemnity insurance and registration details (where required by National or State legislation).
- (b) Following receipt of a completed Application Form:
 - (i) the Chief Executive Officer or delegate, must give the form to the relevant Credentialling Committee(s) or committee authorised by the Executive Director or Chief Executive Officer;
 - (ii) the Credentialling Committee(s) or authorised committee must review the application, satisfy itself as to the Applicant's Credentials, taking into account current Scope of Clinical Practice (if any) and the Hospital's Needs and Hospital's Capabilities, and make recommendations as to the practitioner's Accreditation and Scope of Clinical Practice;
 - (iii) following a determination of its recommendation, the Credentialling Committee or authorised committee must forward its recommendation to the Chief Executive Officer or delegate;
 - (iv) the Board or its delegate must make a final determination as to the application.

39. COMMUNICATION OF DECISION

Within 14 days of arriving at its decision, the Chief Executive Officer must notify the applicant in writing of the decision.

40. TERM OF ACCREDITATION

- (a) Initial Accreditation is for a maximum of 12 months but may be extended to a maximum period of two years depending on the frequency of Hospital visits.
- (b) Accreditation after initial Accreditation is for a maximum of five years

41. SCOPE OF PRACTICE

- (a) The scope of practice of another Health Practitioner will be defined by the usual scope of practice of the profession.
- (b) An applicant practitioner requesting to practice beyond the usual scope of the profession will require application for an extended scope of practice. The threshold requirements for an extended scope of practice will be determined by the credentialling committee or authorised committee and will be informed by appropriate professional standards and/or advice.

42. TERMS AND CONDITIONS

All practitioners accredited pursuant to this Part E must comply with the Terms and Conditions of Accreditation as set out in by-law 20, as applicable.

43. RIGHTS OF APPEAL

All practitioners pursuant to this Part E will have right of appeal as outlined in by-laws 24 and 25.

44. SUSPENSION, TERMINATION AND REVIEW OF ACCREDITATION

The Chief Executive Officer and/or Board may suspend, terminate or review the accreditation of an Other Health Practitioner as outlined in by-laws 22 and 23.

PART of GENERAL PROVISIONS

45. CONFLICT OF INTERESTS

- (a) If a member of any Hospital or Mater Health Services committee or a person authorised to attend any committee meeting has an actual or potential conflict of interest:
- (i) in a matter that has been considered or is about to be considered at a meeting; or
 - (ii) in a thing being done or about to be done by a Hospital or Mater Health Services, then the member or person must disclose the nature of that interest at the meeting.
- (b) Subject to by-laws 37(e) and (f), if a member of any Hospital or Mater Health Services committee or a person authorised to attend any committee meeting has an actual or potential conflict of interest, the member or person:
- (i) may not participate in the relevant discussion or resolution of any relevant interest or matter; and
 - (ii) is not eligible to exercise any office to which the actual or potential conflict of interest applies.
- (c) For the purposes of by-laws 37(a) and (b), an actual or potential conflict of interest includes but is not limited to:
- (i) a direct or indirect financial interest;
 - (ii) a direct or indirect business, employment, or partnership relationship; and
 - (iii) a direct or indirect significant personal interest.
- (d) A disclosure by a person at a meeting of the committee that the person:
- (i) is a member, or is in the employment of, the specified company or other body;
 - (ii) is a partner or is in the employment of, or has a business relationship with, a specified person; or
 - (iii) has some other specified interest relating to a specified company or other body or a specified person, is 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.
- (e) The committee must cause particulars of any disclosure made under by-law 37(a) to be recorded and declared by the member or authorised person in writing on an actual or potential conflict of interest declaration form.
- (f) The chairperson of the committee must make a determination in relation to the disclosure under by-law 37(a) of an actual or potential conflict of interest. Among other things, the chairperson may determine that the member or person must not participate in the meeting when the matter is being considered or that the member or person must not be present while the matter is being considered at the meeting or that the person may participate fully in the meeting when the matter is being considered.
- (g) The chairperson of the committee must advise the Chief Executive Officer of any actual or potential conflict of interest disclosure, and whether the person who made the disclosure participated in the matter to which the disclosure related.
- (h) For the purposes of this by-law 37, the fact that a member of a Credentialling Committee is a member of a particular discipline will not be regarded as an actual or potential conflict of interest, if that committee member participates in the Accreditation process of an Accredited Practitioner in the same discipline.

46. RESEARCH

Research involving human subjects that is proposed to be conducted in or at a Hospital is only permitted if:

- (a) the Scope of Clinical Practice of any Accredited Practitioner to be involved in the research includes clinical activity of the kind proposed in the research;

- (b) the Hospital is satisfied that appropriate insurance cover and indemnity arrangements with any sponsor and other relevant party are in place;
 - (c) if required under the National Statement, the research has been reviewed and approved by an appropriately constituted human research ethics committee acting in compliance with the National Statement and the research is conducted in accordance with the terms of that approval;
 - (d) approval for the conduct of the research has been obtained from the Hospital; and
 - (e) the research complies with the Code of Ethical Standards.
- (e) The Executive Director may refuse permission for the introduction of a New Clinical Service, Procedure or Other Intervention.
 - (f) Before approving the introduction of a New Clinical Service, Procedure or Other Intervention the Executive Director must:
 - (i) 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 Hospital;
 - (ii) where the New Clinical Service, Procedure or Other Intervention involves human research, be satisfied that the requirements of by-law 38 have been met;
 - (iii) be satisfied that the appropriate indemnity and insurance arrangements are in place; and
 - (iv) notify the Credentialling Committee of the decision.

47. NEW CLINICAL SERVICES, PROCEDURES OR OTHER INTERVENTIONS

- (a) An Accredited Practitioner who proposes to perform a New Clinical Service, Procedure or Other Intervention must apply to the Executive Director of a Hospital for approval.
- (b) The Executive Director must refer the application to the Credentialling Committee.
- (c) The Credentialling Committee must advise the Executive Director:
 - (i) whether, and under what conditions, the New Clinical Service, Procedure or Other Intervention could be introduced safely to the Hospital, with reference to the Hospital's Needs and Capabilities; and
 - (ii) whether the New Clinical Service, Procedure or Other Intervention is consistent with the Accredited Practitioner's Scope of Clinical Practice.
- (d) The Executive Director may seek additional advice about the financial, operational or clinical implications of the introduction of the New Clinical Service, Procedure or Other Intervention.

48. DISPUTES ABOUT THE BY LAWS

Any dispute or difference which arises 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 will be determined by the Board.

49. MAKING AND AMENDING THE BY LAWS

The Board may, normally after due consultation, from time to time make, vary or revoke these By-Laws.

