The Purpose of these By-Laws

Montserrat Day Hospital aims to provide the highest standard of care and services for patients admitted to our facilities. We do this in partnership with credentialed medical specialists, and take pride in growing effective relationship with other specialists.

Contents

Section 1:

Section 1

THESE BY-LAWS

This document sets out what are described as the current 'By-Laws' for use in relation to hospitals owned or operated by MB Healthcare Pty Ltd and its subsidiaries:

THESE BY-LAWS:

What are these By-Laws?

1. These By-Laws are created by Montserrat Day Hospitals and approved by its Board of Directors.
2. These By-Laws are intended by Montserrat Day Hospitals to be adopted by every facility operated by Montserrat Day Hospitals Australia
3. These By-Laws are intended for use by both Montserrat Day Hospital's Credentialed Medical Practitioners and other Visiting Health Professionals who hold accreditation with respect to a Montserrat Day Hospital facility and are the standards and rules to be followed to ensure continued credentialing with Montserrat facilities.

How are these By-Laws changed?

4. These By-Laws are changed by a resolution of the Board of Directors of MB Healthcare Pty Ltd ("Montserrat").
5. Every change to these By-Laws takes effect from the time of any resolution by the Board.

What are the purposes of these By-Laws?

These By-Laws have many purposes. Specifically they:

6. Serve to maintain and improve the deliverance of safety and quality for our hospital services;
7. Protect Montserrat Day Hospitals and Credentialed Medical Practitioners (etc.) by ensuring that the environment in which hospital and medical services are delivered supports and facilitates both safety and quality;
8. Define the relationship between a Montserrat Day Hospital and its Credentialed Medical Practitioners and also serve to clarify the mutual responsibilities of those parties; and
9. Assist in compliance with Commonwealth and State laws, regulations and standards; and in particular the 'Standard for Credentialing and Defining the Scope of Clinical Practice' and the National Safety and Quality Health Service Standards as defined by the Australian Commission for Safety and Quality in Health Care (ACSQHC); & the Queensland, Western Australian and New South Wales Clinical Services Capability Framework/s, and other similar State frameworks and legislation.

What do the By-Laws contain?

10. These By-Laws reflect the current environment in which Montserrat is operating. Changes to the law, altered perceptions of clinical best practice, the economic and risk environments in which health care is delivered and the governance structures (both

clinical and corporate) of Montserrat Day Hospitals are all factors which influence the By-Laws and their implementation.

These By-Laws contain policies on the following:

a. The terms and conditions for which Health Practitioners will be credentialed and will continue to hold accreditation;
b. The processes that lead to accreditation and defining the 'Scope of Practice' of credentialed Medical Practitioners (etc.);
c. The role of the Medical Advisory Committee and its sub-committees in the processes of Accreditation at Montserrat Day Hospitals;
d. The administrative and clinical responsibilities of credentialed Health Practitioners.

What these By-Laws are not

11. Although these By-Laws refer to specific policies that have a direct relevance to the processes of accreditation and defining a credentialed Health Practitioner's Scope of Practice, these By-Laws do not:
    a. Communicate every policy of Montserrat Day Hospitals; or
    b. Prevent the Board from making decisions that will have an effect on these By-Laws.

Section 2

MEDICAL ADVISORY COMMITTEE

MEDICAL ADVISORY COMMITTEE (MAC)

12. The purposes of the MAC is to:
    a. Advise the CEO with respect to the clinical and related issues placed before it;
    b. Represent the collective views of the credentialed Health Practitioners who are accredited with respect to the hospital;
    c. Provide a representative forum for communication from and on behalf of the CEO/Board and vice versa to the Medical Practitioners who are credentialed at any Montserrat facility;
    d. In consultation with the CEO, refer matters of clinical safety and quality of care to expert review, whether this be either the hospital's own clinical governance committees or to external authorities or professional organisations;
    e. The MAC (and every sub-committee of it) has the powers, authorities and responsibilities delegated to it by the CEO and Board;
    f. The MAC will be subject to specific 'Terms of Reference' that give guidance both to the duties of the MAC and the administrative rules under which they are to be undertaken;
    g. The MAC may appoint a sub-committee to investigate or consider any matter that has come before it. The members of the sub-committee, and other administrative matters concerning that sub-committee, will be determined by the CEO and Board Chairman in consultation with the Chairman of the MAC; and
    h. Notwithstanding Clause 12(g) of these By-Laws, if the CEO considers that the MAC is inappropriate or insufficient for any reason he/she may create another committee for this specific purpose. The members of the newly created committee are not limited to credentialed Health Practitioners who have been accredited to the hospital. The CEO/Board Chairman are to determine the powers, authorities and responsibilities that are delegated to that committee and the administrative rules they are to operate under.

External members of MAC

13. The CEO may appoint one or more external persons including consumer representatives, (who are not credentialed Medical Practitioners) to the MAC. This can be for a specific time or issue, or generally if the CEO considers that the MAC requires their assistance.

Indemnity to Members of Committees

14. Montserrat Day Hospitals will keep the members of the MAC and its committees indemnified against every cost, claim and demand which is made against any of them in relation to the performance of their functions on a committee, provided that:
    a. They have performed their functions in good faith and without demonstrated malice;
    b. They maintain confidentiality of any conversation or materials and patient (or other) outcomes made available for committee review.

Section 3

ACCREDITATION

ACCREDITATION

Generally

15. The CEO of Montserrat Day Hospitals can authorise a Medical Practitioner (etc.) to use a Montserrat Hospital facility for the treatment of patients if he/she is satisfied as to all of the following:
    a. That each treatment of a patient is supported by the credentials of the Health Practitioner;
    b. That the Health Practitioner will continue to observe the current processes of the hospital, admission criteria and theatre management systems;
    c. That the hospital is able to provide appropriate staff, facilities and support to the Health Practitioner in each treatment of a patient; and
    d. That each treatment of a patient is amenable to the safe and efficient functioning of the hospital as a whole.

16. A Health Practitioner is able to use the facilities of Montserrat Day Hospital's within the speciality that they are credentialed for, for the treatment of their patients whilst they have the continuing authority from the CEO and Board.

17. Scope of Practices
    During the regular Committee meetings, the Credentialing Committee will determine the scope of practice allowed for each candidate who has applied to be a credentialed Medical Practitioner at Montserrat Day Hospitals.

18. Change in Scope of Practice and Introduction of New Clinical Service
    If a credentialed Medical Practitioner is contemplating a change in Scope of Practice, a letter must be written to the Secretary of the Credentialing Committee including any documentation supporting the intended change. The Committee will then assess the change and make their recommendations to the CEO.

19. Research
    If a credentialed Medical Practitioner is intending to conduct research, a letter which includes supporting documentation should be submitted to the Secretary of the MAC. Ethical review and approval may be sought externally and the MAC committee will make their recommendations to the CEO, who will make a decision in conjunction with the Chairman of Montserrat Board.

20. Re-Accreditation, Re-Credentialing and Re-Defining Scope of Practice
    All credentialed Medical Practitioners are required to reapply for Accreditation prior to the expiration of their existing privileges. The Secretary of the Credentialing Committee will contact the credentialed Health Practitioner prior to the expiration of the privileges to progress the reaccreditation process. Any other required changes including re-definition

of scope of practice will need to be submitted to the Secretary of the Credentialing Committee.

21. Professional capabilities for Health Care Professionals

A. Interpersonal

The Medical Practitioner will act with dignity, honesty and respect for:

- Staff;
- Other health care professionals and Medical Practitioners;
- The structure of the organisation and its authority and responsibility; and
- Quality and risk management initiatives at Montserrat Day Hospitals

B. Patient relationship

It is expected that the Medical Practitioner will:

i) Establish an empathetic and professional relationship, provide high quality clinical services, and an appropriate level of service relative to the clinical problem.
ii) The responsibility for delivery of medical care is between the patient and medical practitioner. Montserrat aims to work with the Medical Practitioner to maintain this high standard.

C. Open Disclosure

It is a policy of Montserrat Day Hospitals to adhere to the National Open Disclosure Standard, which promotes a clear and consistent approach to how Australian Hospitals open communications with patients and nominated family members following an adverse event. It includes guidelines for discussion about what has happened and why as well as what is being done to prevent it happening again. (Reference the Australian Standard for Safety and Quality in Healthcare - Open Disclosure Standard).

D. Personal behaviour

It is expected that the Medical Practitioner will:

i) Maintain and provide his/her relevant registrations and accreditations as necessary.
ii) Maintain relevant "maintenance and professional standards" and also Continuing Professional Development documentation through the relevant college.
iii) Practice with strong focus on "evidence-based" medical principles.
iv) Adhere to the Australian and State Government legislation and the provisions of the current State's Health Department Clinical Services Capability Framework.
v) Adhere specifically to the requirements of hospital accreditation and the National Standards for Safety and Quality in Health Care.
vi) Report all incidents, hazards and complaints using the Risk Clear program or report to the Clinical Manager for input into the Risk Clear program in a timely manner, including those occurring after discharge. E.g. hospital admissions, infections etc.
vii) Abide by the relevant policies and procedures of MDH including the management of patients in the absence of the Principle Medical Officer.
viii) Ensure he/she is always abiding by the principles of the Privacy Legislation.
ix) Maintain confidentiality regarding any business strategies or goals of Montserrat that he/she may be aware of, including related health clinics and associated entities.

x) Maintain confidentiality regarding Montserrat personnel.
xi) Use IT systems provided to streamline processes within Montserrat Day Hospitals.
xii) Practice in a manner which is cost sensitive and avoids unnecessary waste of materials, services and staff.
xiii) Actively participate in the formal ongoing education of clinical and other staff.
xiv) Schedule consultations before or after theatre lists rather than during to avoid delays to theatre lists, patient complaints and increased staffing costs.

Health Practitioners must be Accredited to admit patients

22. A Health Practitioner may treat patients at Montserrat only if credentialed to undertake that treatment at that hospital and the hospital is licenced to undertake the procedure.
23. Credentialing of a Health Practitioner is limited to:
    a. The Montserrat Day Hospitals or Montserrat Day Hospitals named in the Accreditation Notification; and
    b. The Scope of Practice identified in the Accreditation Notification.
24. Holding credentialing with Montserrat Day Hospitals does not give the Medical Practitioner any right or entitlement to, or guarantee of:
    a. Any level of availability of theatre access at the hospital;
    b. Any allocation of operation session time; or
    c. The allocation of any patient.

Application for Accreditation:

25. A Medical Practitioner who wishes to apply for Credentialing with respect to a Montserrat Day Hospital must submit a completed Montserrat Credentialing Application form to the CEO via the Credentialing Officer.
26. The application must:
    a. Specify the Scope of Practice you are applying for ; and
    b. Include every document specified in the prescribed form.
    c. Specify the Montserrat Day Hospital location/s you are applying for.

Compliance with By-Laws:

27. Every applicant for Accreditation must acknowledge in writing that he or she will comply with and be bound by these By-Laws.

Process on receipt of Application for Accreditation:

28. On first receiving an application for credentialing at a Montserrat Day Hospital, the CEO of Montserrat Day Hospitals may choose to reject the application at their discretion without assigning a reason for this decision, however the applicant must be notified in writing of this refusal of privileges.
29. The CEO is not able to automatically reject the renewal of credentialing of an existing credentialed Medical Practitioner.
30. If the CEO:
    a. Does not reject the application for credentialing on first receiving it; and

b. Considers the application is likely to meet the general principles of Clauses 25 and 26 of these By-Laws; the CEO must then forward it to the Credentialing Committee for review and recommendation.

Credentialing Committee

31. The function of considering applications for credentialing, and of formulating recommendation to the CEO on Credentialing, Re-Credentialing and defining the Clinical Scope of Practice of Medical and Health Practitioners, must be performed by a Credentialing Committee.
32. The Credentialing Committee must be a sub-committee of the MAC that has been convened for that purpose.
33. 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.
34. Unless otherwise provided within these By-Laws, if an equality of votes occurs, the CEO and/or Chairperson of the Board shall have a casting vote in addition to a deliberative vote.

Process of the Credentialing Committee

35. The Credentialing Committee must consider every application without undue delay.
36. The Credentialing Committee may invite oral submissions from the applicant when considering an application for Credentialing.
37. The Credentialing committee may co-opt other Health Practitioners:
    a. From the Accredited Health Practitioners at the Montserrat Day Hospitals where the Credentialing Committee performs its functions; or
    b. That are suitably experienced, qualified and independent of the hospital to assist in the Credentialing Committee's deliberations and peer review.
38. Members of the Credentialing Committee must declare and, where necessary, refrain from participation in the deliberations where a situation of conflict of interest exists.
39. In considering an application for Credentialing, the Credentialing Committee must take account of all of the following:
    a. Whether, and to what extent, the qualifications, experience, skills and training of the applicant support the classification sought by the application.
    b. The character and standing of the applicant, and whether the applicant is a suitable person to practise at Montserrat Day Hospitals.
    c. Whether the hospital has the facilities to support the fields of practice proposed by the applicant.
    d. Whether, in its opinion, the applicant will continue to observe the current processes of the hospital.

e. In making recommendations for Re-Credentialing, the Credentialing Committee must have regard for matters including, but not limited to:
   i) The clinical performance of the applicant, including patient outcomes, adverse events, complaints, participation in internal and external audits and quality assurance activities as well as continuing professional development programmes of respective Colleges and Professional Bodies; and
   ii) Significant and persistent non-compliance with By-Laws.
   iii) The Credentialing Committee may decline to make a recommendation to the CEO following its consideration of an application for Accreditation.
   iv) The Committee may seek advice from a nominee of the relevant learned College or Professional Body who is independent of the hospital and has no conflict of interest with the applicant, prior to making a recommendation to the CEO that may be adverse to the applicant.
   v) In addition to its recommendation to the CEO, the Credentialing Committee may make recommendations concerning any Special Conditions which it believes should apply to the Accreditation of the Practitioner.

Decision by CEO

40. Where the CEO has referred an application for Accreditation to the Credentialing Committee, the CEO must take into account any recommendation made by the Credentialing Committee before making a decision on the application.
41. Except in cases of renewals (Clause 20), the CEO may refuse the application for accreditation.
42. The CEO must notify the Medical Practitioners of the accreditation and the notification must set out the particulars of that Accreditation, including;
    a. The Medical Practitioner's Scope of Practice;
    b. Any Special Conditions that will apply to the Accreditation;
    c. The term of the Accreditation; and
    d. At which hospitals the Medical Practitioner (etc.) holds Accreditation.
43. For the first credentialing application, the CEO is not required to provide any reasoning for the decision on the application, if the CEO:
    a. Refuses the applicant's application; or
    b. Makes the applicant's Accreditation subject to any Special Conditions; and
    c. If the application is to renew an existing Accredited Health Practitioner, the CEO must provide means for rejection or renewal and the applicant may appeal the CEO's decision in accordance with these By-Laws.

Term of Accreditation

44. A Medical Practitioner (etc.) is credentialed only for the period of three years or as specified in the Accreditation Notification.

Temporary Accreditation

45. Subject to compliance with credentialing application processes of these By-Laws, the CEO of Montserrat Day Hospital may authorise the Medical Practitioners (etc.) to treat patients at the hospital before the application has been finally determined. This is a Temporary Accreditation.
46. Temporary Accreditation enables a Medical Practitioner to treat patients at the specified Montserrat Day Hospitals until the earlier of the following:
    a. The CEO has notified the Medical Practitioner of the decision on the Medical Practitioner's application for Accreditation.
    b. A specified date.
47. The maximum period of temporary Accreditation that can be authorised by the CEO is six months from the date of advice to the applicant.
48. The granting of temporary Accreditation must be reported to the next meeting of the Credentialing Committee and documented in the Committee minutes.
49. A Medical Practitioner who treats his or her patients at a Montserrat Day Hospital where he or she has been given temporary Accreditation must comply with the terms of that temporary Accreditation and these By-Laws.

Re-Credentialing

50. A credentialed Medical Practitioner (etc.) with respect to a Montserrat Day Hospital must apply for a renewal of their Accreditation 90 days prior to the end of their Accreditation period. This is to be done on the required Montserrat Renewal form and submitted to the Credentialing Officer.
51. The administrative processes for a renewal must be the same as for an initial application for Accreditation, other than where these requirements have been waived by the CEO pursuant, and in compliance with Clause 29 of these By-Laws.
52. The CEO, after consultation with the Chairperson of the MAC and/or Chairperson of the Board, may waive any requirements with respect to an application for renewal of a previous or existing Accreditation if those requirements appear unnecessary or irrelevant.

Lapse of Accreditation

53. Where a Credentialed Medical Practitioner (etc.) does not seek renewal of his or her Accreditation prior to the expiration of the term of Accreditation, the Accreditation will lapse on the last day of the period for which he or she has been accredited.
54. If the Medical Practitioner (etc.) fails to observe the clinical services capability framework as set out by Queensland Health without, in the view of the Credentialing Committee or MAC, adequate explanation, will be referred to the Board for consideration and the Board has the final determination for continuing credentialing.

Section 4

RESIGNATIONS, VARIATIONS, SUSPENSION OR TERMINATION OF ACCREDITATION

RESIGNATION, VARIATION, SUSPENSION OR TERMINATION OF ACCREDITATION

Resignation or Extended Absence of an Accredited Health Practitioner

55. An Accredited Medical Practitioner who intends to cease treating patients either indefinitely or for an extended period at a Montserrat Day Hospital in respect of which he or she is accredited should notify that intention to the CEO.

Accredited Health Practitioner may request variation of Accreditation

56. An Accredited Medical Practitioner may request a variation to his or her Accreditation in respect of a Montserrat Day Hospital at any time following the same process as an application for Accreditation, submitted to the Credentialing Officer.

Allegations Concerning Accredited Health Practitioners

57. The CEO of Montserrat Day Hospital's may investigate an allegation against an Accredited Health Practitioner if the CEO considers that, if the allegation were true, it could result in any of these outcomes:
    a. The health or safety of any patient could be compromised;
    b. The efficient operation of the hospital could be threatened;
    c. The rights of a patient or someone engaged in, or working at the hospital could be infringed; or
    d. The Accredited Medical Practitioner may be found to have breached any law.
58. An Accredited Health Practitioner against whom an allegation has been made:
    a. Must be informed of the allegation in the presence of the CEO and/or the Chairman of the Board.
    b. Must be given reasonable opportunity to provide an explanation to the CEO and or Chairman of the Board in response to the allegation.
59. If the CEO and/or Chairman of the Board:
    a. Is not satisfied that the allegation is false after hearing any explanation by the Accredited Medical Practitioner in response to the allegation;
    b. Considers that additional information is required to form a view as to whether the allegation is true or false; or
    c. Is unsure whether the allegation, if true, would lead to any of the outcomes in Clause 57 then;
    d. The CEO in consultation with a Company Director may convene a committee of "Three Wise Men" to assist him or her to investigate the allegation further;
    e. The CEO may terminate, suspend or impose conditions on the Accreditation of the Accredited Medical Practitioner (etc.) until such time as the CEO is satisfied that the allegations have been resolved.
60. The "Three Wise Men" Committee assisting the CEO and/or Board Chairman:
    a. Must be competent in the speciality to consider the allegation;
    b. Must be unbiased;
    c. Must execute confidentiality agreements if required in a form prescribed by the CEO;

d. Is entitled, if it wishes, to question the Accredited Health Practitioner in relation to those allegations; and
e. Must provide the CEO with its written conclusions and/or opinions supported by reasons.

61. The CEO must advise the Credentialed Medical Practitioner (etc.) of the decision as soon as reasonably possible after receiving the committee's written conclusions and/or opinions.
62. If the CEO chooses to terminate or suspend an Accredited Medical Practitioner's Accreditation in respect of the hospital in accordance with these By Laws, the Practitioner may appeal that decision in accordance with relevant clauses of these By-Laws.
63. In addition to or as an alternative to the provisions of these By-Laws, the CEO;
    a. Where legally required, must notify the Australian Health Practitioner Regulation Agency of the alleged facts, matters or circumstances surrounding the allegation;
    b. May notify the Australian Health Practitioner Regulation Agency of the alleged facts, matter or circumstances that are the subject of the allegation if the CEO considers such notification to be:
        i. In the best interests of patient care or safety in any place to do so;
        ii. Necessary to protect the reputation of Montserrat Day Hospitals.

Suspension of Accreditation by CEO

64. In consultation with the Chairman of the Board, the CEO of Montserrat Day Hospitals may suspend an Accredited Medical Practitioner's (etc.) Accreditation in respect of that hospital if the CEO forms the view that;
    a. To do so would be in the interests of patient care or safety;
    b. To do so would be in the interests of staff welfare or safety;
    c. Serious and unresolved allegations have been made relating to the Health Practitioner;
    d. The Accredited Health Practitioner has breached any General Conditions or Special Conditions of Accreditation;
    e. The conduct of the Accredited Health Practitioner compromises the efficient operation or the interests of the hospital; or
    f. There are other unresolved issues in respect of the Accredited Health Practitioner that the CEO, the MAC and/or the Board of Montserrat Day Hospitals consider are grounds for suspension.
65. The CEO can't suspend an Accredited Medical Practitioner's Accreditation unless there is reasonable belief that the cause of the suspension can be resolved, and in a timely manner.
66. The CEO must notify an Accredited Health Practitioner in writing of:
    a. The suspension of his or her Accreditation, including the period of it and reasons for it;
    b. Any actions that must be performed for the suspension to be lifted and the period within which those actions must be completed;

c. The Health Practitioner's right to appeal the CEO's decision to suspend the Health Practitioner's Accreditation.

67. The suspension of a Practitioner's Accreditation ends when:
    a. The CEO notifies the Health Practitioner in writing that the Health Practitioner's Accreditation is terminated; or
    b. The CEO notifies the Health Practitioner in writing that the suspension of the Health Practitioner's Accreditation is lifted.
68. The resumption of Accreditation by a (previously) suspended Practitioner is always subject to the Practitioner observing the requirements for continuous disclosure in the By-Laws.
69. A Practitioner may appeal the suspension of his or her Accreditation in accordance with relevant clauses in these By-Laws.

Termination of Accreditation

70. The CEO and/or Board Chairman of a Montserrat Day Hospital may, by written notice, immediately terminate an Accredited Health Practitioner's Accreditation in respect of that hospital if:
    a. The Accredited Practitioner ceases to be a 'Medical Practitioner' (etc.) as defined by the Health Practitioner Regulation National Law;
    b. The Accredited Medical Practitioner's registration is suspended under Medical Practitioner Regulation National Law;
    c. The registration of the Accredited Medical Practitioner under the Health Practitioner Regulation National Law becomes subject to any condition which, in the CEO's opinion, cannot be adequately satisfied at the hospital;
    d. The Accredited Medical Practitioner fails to observe a General Condition or Special Condition of Accreditation;
    e. The CEO and/or Board Chairman forms the view that the Accredited Practitioner has failed to meet the continuous disclosure requirements of these By-Laws;
    f. The CEO and/or Board Chairman forms the view that there is a serious and unresolved allegation concerning the Accredited Practitioner and that suspension of the Accreditation would be an insufficient response in the circumstances;
    g. The CEO and/or Board Chairman forms the view that the findings of any group investigating an allegation relating to the Accredited Practitioner are sufficient to warrant termination of the Accreditation;
    h. The Accredited Practitioner has been unable to perform his or her patient care and treatment duties at the hospital for a continuous period of 6 months;
    i. The Accredited Practitioner hasn't used admitting rights for 6 months continuously;
    j. The Accredited Practitioner is found guilty of unprofessional conduct and/or unsatisfactory professional conduct by any inquiry, investigation or hearing by any disciplinary body or professional standards organisation;
    k. The Accredited Practitioner is found guilty of unprofessional conduct and/or unsatisfactory professional conduct by any inquiry, investigation or hearing by any disciplinary body or professional standards organisation;

l. The Accredited Practitioner is found guilty of any offence which in the reasonable opinion of the CEO and/or Board Chairman is likely to bring that Practitioner into professional disrepute or likely to harm the reputation of any Montserrat Day Hospital;
m. The hospital ceases to provide support services required within the Scope of Practice in which the Practitioner is accredited;
n. The Accredited Practitioner fails to maintain appropriate insurance cover.

71. The CEO and/or Board Chairman must not terminate an Accredited Practitioner's Accreditation unless he/she reasonably believes that the cause for termination cannot or should not be resolved by suspension.
72. The CEO and/or Board Chairman must notify an Accredited Health Practitioner in writing of:
    a. The termination of their Accreditation, including the reasons for it;
    b. The Practitioner's right to appeal the decision to terminate the Accreditation.
73. A Practitioner may appeal the termination of his or her Accreditation in accordance with relevant clauses of these By-Laws.

Effect of suspension or termination of Accreditation at other Montserrat Day Hospitals

74. If the CEO and/or Board Chairman of Montserrat Day Hospital suspends an Accredited Practitioner's Accreditation in respect to a Montserrat Day Hospital, the suspension will simultaneously be suspended across all Montserrat Day Hospital to which they hold accreditation and any conditions imposed will apply across all Montserrat Day Hospitals.
75. Clause 74 applies even if the Health Practitioner is accredited at the other hospital after his or her Accreditation is suspended in respect of the first hospital.
76. Subject to relevant clauses of these By-Laws, if the CEO and/or Board Chairman of Montserrat Day Hospital's terminate an Accredited Practitioner's Accreditation in respect to a Montserrat Day Hospital, the termination will simultaneously apply to all other Montserrat Day Hospitals where the Accredited Practitioner holds Accreditation.
77. Clause 76 of these By-Laws does not apply if the CEO and/or Board Chairman of the first hospital terminates an Accredited Practitioner's Accreditation in respect of that hospital only because the first hospital ceases to provide support services required within the Scope of Practice in which the Practitioner is accredited.

Section 5

APPEALS

APPEALS

No right of appeal unless specifically conferred

78. A Medical Practitioner (etc.) has no right to appeal:
    a. Any decision made in accordance with these By-Laws; or
    b. Any decision purportedly made in accordance with these By-Laws; unless these By-Laws expressly give the Health Practitioner a right to appeal that decision.
79. A Medical practitioner has no right to appeal the exercise of any discretion conferred by these By-laws.

Right to appeal the decision of the CEO

80. If a Medical Practitioner wishes to appeal a decision of the CEO in respect of which these By-Laws give the Medical Practitioner a right of appeal, the Medical Practitioner must lodge an appeal in writing with the CEO within 30 days of being notified of the decision.
81. It is sufficient to lodge an appeal in writing for the Medical Practitioner to:
    a. State that he or she appeals a decision of the CEO in respect to which these By-Laws give the right of appeal; and
    b. Specify the reason for the appeal.
82. Where a Medical Practitioner who has the right to appeal, as per these By-Laws does not do so following Clause 80 and 81, the right to appeal is extinguished.

Procedure for appeal

83. The CEO must refer every appeal to the Board Chairman and/or Board Director as soon as practicable after receiving the appeal.
84. On being referred an appeal, the CEO and/or Board Chairman must decide as soon as practicable whether the appeal is to be determined:
    a. By the CEO and Board Chairman alone; or
    b. By a committee of "3 Wise Men" constituted in accordance with relevant clauses of these By-Laws.
85. If the CEO and/or Board Chairman decide that the appeal is to be determined by them alone, the CEO must follow the procedure set out in relevant clauses of these By-Laws.
86. If the CEO and/or Board Chairman decide that the appeal is to be determined by an Appeals Committee, the CEO must constitute and convene the Appeals Committee as soon as practicable.
87. Subject to relevant clauses when constituting an Appeals Committee, the Board Chairman and/or CEO:
    a. Must be a member of the Appeals Committee;
    b. Must be the Chairman of the Appeals Committee;
    c. May seek nominations from any relevant learned Colleague, Professional Body, association or society that he or she sees fit to include on the Appeals Committee;
    d. May appoint any individual who can bring specific expertise to the Appeals Committee;

e. Must try to avoid appointing persons who have a conflict of interest or commercially competitive relationship with the Appellant.

88. If the Board Chairman or CEO decides that the appeal is to be determined by an Appeals Committee, the process must follow the procedure set out in Clauses 89-93 of the By-Laws once the Appeals Committee has been constituted.
89. Subject to relevant clauses of these By-Laws, prior to the Board Chairman, CEO or an Appeals Committee (as the case may be) determining an appeal, the following must be undertaken:
    a. Invite the Appellant to provide written submissions setting out the basis upon which he/she contends that the Chairman and/or CEO's decision was not reasonably fair at the time the decision was made, this is to be done within reasonable time period;
    b. Invite the Appellant to make any additional oral submissions with respect to why they believe the CEO's decision should be reversed or varied, any time and place nominated by the Board Chairman and/or CEO.
90. When making any oral submissions to the Board Chairman, CEO or Appeals Committee further to an invitation made in accordance with Clause 89 of these By-Laws:
    a. The Appellant is not entitled to legal representation;
    b. The Appellant is not entitled to have a legal representative present.
91. If the decision of the Board Chairman and/or CEO that is the subject of an appeal is a decision which:
    a. Joint written submissions setting out the basis upon which the Chairman and/or CEO made the decision the subject of the appeal; and
    b. The evidence upon which the Chairman and/or CEO based his or her decision.
92. When determining an appeal:
    a. The Board Chairman, CEO or Appeals Committee (as the case may be) must decide whether, on the basis of the evidence available to them at the time the decision, that the decision was reasonably fair.
93. Upon determining the appeal, the Board Chairman, CEO and/or Appeals Committee:
    a. Must set out the decision on the appeal in writing, and state the reasons for the decision on the appeal; and
    b. Must provide a copy of the decision on the appeal and reasons for the decision on the appeal to:
        i. The Appellant; and
        ii. The Chairman and/or CEO who made the decision that was the subject of the appeal; as soon as practicable after the appeal is determined.

Section 6

GENERAL CONDITIONS OF ACCREDITATION

GENERAL CONDITIONS OF ACCREDITATION

Accreditation is Personal

94. The Accreditation of a Medical Practitioner is personal and cannot be transferred to, or be exercised by, any other person.

Accreditation permits a delineated Scope of Practice

95. An Accredited Medical Practitioner must admit and treat patients only within the delineated Scope of Practice in his or her Accreditation Notification, compliance with 'General Conditions' and 'Special Conditions' of Accreditation.
96. An Accredited Medical Practitioner (etc.) must comply with the General Conditions and any Special Conditions. To the extent of any inconsistency between the General Conditions and the Special Conditions, the Special Conditions prevail.

Compliance with Laws, Policies and Professional Standards

97. An Accredited Health Practitioner must comply with:
    a. These By-Laws;
    b. All applicable laws concerning the provision of health care services to patients at private hospitals;
    c. The policies, rules and procedures of Montserrat Day Hospitals and the specific Montserrat Day Hospital which they are Accredited;
    d. Accepted professional and ethical standards and relevant codes of conduct.
    e. National and State standards and legislative requirements.

Professional Malpractice Insurance

98. An Accredited Medical Practitioner must maintain and hold professional malpractice liability insurance from a professional indemnity insurer operating in Australia.
99. The professional malpractice liability insurance must indemnify the Practitioner for the entirety of his or her Scope of Practice.
100. Unless exempted by the CEO, such insurance must have no exclusions or deductibles relevant to the Accredited Medical Practitioner's Scope of Practice at the Montserrat Day Hospitals in respect of which he or she is accredited.
101. The limits of indemnity of the policy must be adequate in the opinion of the CEO.
102. An Accredited Medical Practitioner must, if requested by the CEO, provide an authority directed to the Accredited Health Practitioner's professional malpractice liability insurer to provide to the CEO evidence of the terms of that practitioner's insurance, including the limits and currency of that insurance.

Quality Assurance

103. An Accredited Health Practitioner must:
    a. Participate in Continuing Professional Development programmes concerning his or her discipline or specialty, not less than once in each period of three (3) years, or more frequently if required by the CEO and provide evidence to the CEO of this participation.
    b. Participate in quality assurance (including clinical audit) programmes approved by the MAC or relevant Department;
    c. Participate in the review of clinical performance indicators and other measures of clinical care;
    d. (If the Accredited Health Practitioner is a Medical Practitioner) participate in audit and educational activities as required by the clinical College or Professional Body awarding the qualifications upon which the Accredited Health Practitioner's Accreditation is based;
    e. Assist Montserrat Day Hospitals, in respect of which he or she is accredited, in achieving accreditation standards as set by the Accreditation Standards, the Australian Commission on Safety and Quality in Health Care and other bodies charged with the accreditation and licensing of hospitals standards;
    f. Advise the CEO of any Montserrat Day Hospitals in respect of which he or she is accredited as soon as practicable of any complaints or incident which may lead to a claim brought against that hospital on the grounds of negligence, breach of licensing conditions or a failure to provide safe working conditions;
    g. Assist in the resolution of complaints against:
        i. Any Montserrat Day Hospitals in respect of which he or she is accredited;
        ii. The Accredited Health Practitioner himself or herself.

Respect for Colleagues and Staff

104. An Accredited Health Practitioner must treat fairly and with respect:
    a. All Health Practitioners who are accredited with respect to Montserrat Day Hospitals;
    b. All staff and all other people working at or engaged by the hospital.
105. An Accredited Health Practitioner must not bully, harass or intimidate any person and comply with relevant work place diversity legislation and Montserrat Policies.

Section 7

CONTINUOUS DISCLOSURE

CONTINUOUS DISCLOSURE

Continuous Disclosure Requirements

106. An Accredited Medical Practitioner (etc.) must keep the CEO of Montserrat Day Hospital's continuously informed of every fact and circumstance which has a material bearing upon:
    a. The Credentials of the Accredited Medical Practitioner;
    b. The Scope of Practice of the Accredited Medical Practitioner;
    c. The ability of the Accredited Medical Practitioner to safely deliver health care services to his or her patients within that Scope of Practice; and
    d. The ability of the Accredited Medical Practitioner to satisfy a medical malpractice claim made against him or her by a patient.
107. Without limiting clause 106, an Accredited Medical Practitioner (etc.) must advise the CEO of the Montserrat Day Hospital(s) in respect of which he or she has been accredited if:
    a. He or she ceases to be Registered, or is suspended from registration, under the *Health Practitioner Regulation National Law*;
    b. He or she has any conditions, limitations or restrictions imposed upon their registration under the *Health Practitioner Regulation National Law*;
    c. He or she is subject to an investigation initiated in respect of any aspect of his or her practice by any registration, disciplinary, investigative or professional body;
    d. He or she is found guilty of professional misconduct and/or unsatisfactory professional conduct by any inquiry, investigation or hearing by any disciplinary or professional body or is subject to an adverse finding by any such body;
    e. 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 or becomes subject to any conditions or restrictions;
    f. He or she suffers from illness, disability or impairment that may adversely affect his/her fitness to practise;
    g. He or she is charged with or convicted of any serious criminal offence;
    h. He or she ceases to hold professional malpractice liability insurance in accordance with the requirements of these By-Laws;
    i. His or her billing privileges are withdrawn or restricted under the Medicare Australia Act 1973 (Cth) because of his or her conduct, professional performance or health;
    j. He/her authority under a law of a state or territory to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of medicine is cancelled or restricted.

Section 8

CLINICAL RESPONSIBILITIES

CLINICAL RESPONSIBILITIES

Admission of patients

108. The admission of an Accredited Medical Practitioner's patient to a Montserrat Day Hospital is subject to:
    a. Procedure/operating list availability;
    b. The availability or adequacy of nursing or allied health staff or facilities at the hospital; relevant to the type or treatment proposed to be conducted by the Accredited Health Practitioner.
109. Except in an emergency, when a diagnosis or reasons for admission must be recorded as soon as practicable after admission, no patient must be admitted to a Montserrat Day Hospital until a valid reason for admission has been stated by the Accredited Medical Practitioner.
110. Planned operating booking lists must be provided three (3) business days prior to the planned list.

Allocation of operating room sessions

111. Sessions for the use of operating rooms are allocated by the CEO to Accredited Medical Practitioners on the basis that they will be fully utilised,
112. The Session allocated to the Accredited Medical Practitioner remains Montserrat Day Hospital's to allocate and is not the Medical Practitioners operating room to claim ownership,
113. Wherever possible, an Accredited Health Practitioner must give to the CEO not less than 28 days' notice of any times during which he or she will not fully utilise any operating sessions that have been assigned to him or her.
114. The CEO may:
    a. Modify or change the allocation of operating sessions having regard to utilisation or the demands for surgery;
    b. Allow casual bookings for the whole or part of any allocated operating session which is not fully utilised;
    c. Upon 28 days' notice to the Accredited Health Practitioner reduce or terminate the Accredited Health Practitioner's allocation of operating sessions.
115. An Accredited Health Practitioner must give the CEO 28 days' notice of his or her intention to reduce or terminate use of allocated operating sessions.

Care of admitted patients

116. Montserrat Day Hospitals support the national clinical guidelines developed collaboratively by organisations such as:
    a. The National Health and Medical Research Council;
    b. The National Institute of Clinical Studies;
    c. The Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIPS);

d. Recognised authorities in evidence-based medicine, such as the Cochrane Collaboration;
e. Specialist training colleges and organisations accredited by the Australian Medical Council;
f. The learned Colleges, Professional Bodies and other clinical professional organisations and societies;
g. Various peak clinical non-government organisations (such as the National heart Foundation, Australian Kidney Foundation, Asthma Foundation, Cancer Foundation); represent the current clinical 'best practice' for many areas of medicine, and should whenever possible and practicable, be consulted for guidance to support informed clinical decision-making and the development of pathways of care that yield optimal clinical outcomes.

117. While all clinical decisions are, ultimately, the prerogative and responsibility of the treating Practitioner, Montserrat Day Hospitals encourages the use of evidence-based clinical guidelines.
118. Each Accredited Practitioner is responsible for the care and treatment of his or her patients in the hospital. If the Practitioner is unable to provide that care personally, he or she must secure the agreement of another Accredited Medical Practitioner to provide that care and treatment.
119. When an Accredited Medical Practitioner has made an agreement to transfer responsibility for the care and treatment of his or her patient to another Accredited Practitioner, the first Accredited Medical Practitioner must:
    a. Note the details of the transfer on the patient's medical record; and
    b. Communicate the transfer to the Clinical Manager or other responsible nursing staff member at the Montserrat Day Hospital to which the patient has been or is to be admitted.
120. An Accredited Medical Practitioner who admits a patient to a Montserrat Day Hospital must:
    a. Give all information to the hospital as may be necessary to assess the patient's risk of self-harm to others; and
    b. Advise hospital staff on the steps necessary to manage the risk of harm and to assure the protection of other patients at the hospital.

Patient Records and Discharge of Patients

121. An Accredited Medical Practitioner must maintain full, accurate and legible medical records for all patients treated by him or her at a Montserrat Day Hospitals.
122. The records must include all information necessary to enable the hospital staff to provide necessary care and treatment to patients.
123. The records must comply with National Standards developed by the Australian Commission on Safety and Quality in Health Care and be in the form determined by the relevant Montserrat Day Hospitals.

124. The Accredited Medical Practitioner must document relevant item numbers (or other) relating to the patient's treatment to allow for accurate billing of Health Funds or Medicare.
125. An Accredited Medical Practitioner who admits a patient to a Montserrat Day Hospital must obtain a 'Consent For Treatment' form from the patient or the patient's legal guardian before the patient is admitted to the hospital, with the exception of emergency cases.
126. Where an Accredited Medical Practitioner who is admitting a patient to a Montserrat Day Hospital has not obtained a 'Consent For Treatment' form from the patient or legal guardian on or before the admission, in accordance with Montserrat Day Hospital policy:
    a. The hospital must notify the Accredited Medical Practitioner that a 'Consent For Treatment' form has not been obtained;
    b. Except in Emergency Cases, the Accredited Medical Practitioner must obtain written informed consent before the patient receives any treatment at the hospital;
    c. Written consent must be received for patients requiring cytotoxic, biological therapy or blood product administration;
    d. Documentation of a patient's refusal of blood product must be obtained.
127. In emergency cases where possible, the signature of two Accredited Health Practitioners who are either Medical Practitioners or Dental Practitioners should be obtained on the 'Consent For Treatment' form attesting to the fact that, in both their opinions, the situation at hand is considered an emergency and that the patient is incapable of giving valid consent.
128. For the purposes of these By-Laws, an emergency exists in any situation where, in the opinion of the treating Medical Practitioner, immediate treatment is necessary in order to avert a serious and imminent threat to a patient's life or physical or mental health.
129. The Attending Medical Practitioner must record an appropriate patient history, physical examination and treatment plan before an operation or any potentially hazardous diagnostic procedure is undertaken. In situations where this has not occurred, the procedure must be delayed:
    a. Until the situation is clarified to the satisfaction of all persons who will be involved in the care of the patient; or
    b. Unless the Accredited Medical Practitioner states in writing that such a delay would be detrimental to the life and recovery of the patient.
    c. Post-operative/procedural completion of the medical record is mandatory in these cases.
130. Operative reports must:
    a. Include a detailed account of the findings at surgery;
    b. Include details of the surgical technique undertaken;
    c. Be written or dictated and the report signed by the Attending Health Practitioner;
    d. Be made part of the patient's medical record; and
    e. Describe relevant item numbers.

131. An Accredited Medical Practitioner who performs anaesthesia on a patient must:
    a. Obtain consent to anaesthesia; and
    b. Maintain a complete anaesthetic record that includes evidence of pre-anaesthetic evaluation and post-anaesthetic follow-up of the patient's condition.
    c. Remain on the hospital site until the patient is reasonably recovered from anaesthetic.
    d. Remain contactable via telephone until the patient's final discharge from the facility.
132. Subject to Clause 130 & 131:
    a. All orders for the treatment of a patient must be:
        i. Recorded legibly in writing, noting the date and time the order is made; and
        ii. Signed by the Accredited Medical Practitioner that ordered the treatment.
    b. Any order for treatment that does not comply with clause 132.a, must not be carried out until:
        i. The order complies with clause 132.a; or
        ii. The order is understood clearly by those involved in the care of the patient.
133. A verbal order for the treatment of a Patient that is given by an Accredited Medical Practitioner may be acted on when:
    a. It is given to a duly authorised person functioning within the scope of their clinical competence; and
    b. The order is understood clearly by those involved in the care of the Patient.
134. A verbal order for the treatment of a patient that is made in accordance with Clause 133 must be recorded in writing and signed by the Accredited Medical Practitioner who gave the verbal order within 24 hours of making the verbal order.
135. The repeated failure of an Accredited Medical Practitioner to comply with Clause 134 must be brought to the attention of the MAC of the Montserrat Day Hospital where the verbal orders were given.
136. Where a specimen is removed from a Patient by an Accredited Medical Practitioner at a procedure:
    a. The specimen must be sent to a pathologist for such examination necessary to arrive at a tissue diagnosis;
    b. The authenticated report prepared by the pathologist must be included in the patient's medical record as soon as practicable after it is received by the Montserrat Day Hospital where the patient was admitted when the specimen was removed.
137. An Accredited Medical Practitioner's attendance on a Patient must be documented in the Patient's medical record, especially where:
    a. There has been a change in the Patient's condition since he or she was last reviewed or;
    b. If the Accredited Medical Practitioner initiates a change in the patient's management.
138. Pertinent progress notes must be recorded at the time of observation, sufficient to permit continuity of care, communication of clinically relevant information to nursing and other staff and transferability of the patient. Wherever possible, each of the patient's clinical

problems should be clearly identified in the progress notes and correlated with specific orders and the results of any tests and treatments undertaken.

139. All clinical entries in a patient's medical record must be accurately dated, timed and authenticated.
140. All medical imaging and pathology reports must be included in a Patient's medical record within 24 hours of receipt by the Montserrat Day Hospital where the patient is or was admitted.
141. The medical record of a patient is the property of the Montserrat Day Hospital to which the patient has been admitted.
142. An Accredited Medical Practitioner must not destroy or remove from a Montserrat Day Hospital premises any medical record or part of a medical record without the prior consent of the CEO.
143. Where a patient is readmitted to a Montserrat Day Hospital, that part of the medical record relating to the patient's previous admissions must be available to the Accredited Medical Practitioner involved in the patient's treatment during the readmission.
144. An Accredited Medical Practitioner must:
    a. Comply with the patient discharge policy of the Montserrat Day Hospital to which the patient is admitted; and
    b. Complete all patient discharge documents, as relevant to the patients care, required by that hospital. The State Health Ombudsman and National Safety and Quality Health Service Standards require that 'a patient's discharge should not be affected without a discharge summary.
145. A patient must be discharged only on the order of the Attending Medical Practitioner (or his or her approved delegate).
146. When a patient chooses to leave the Montserrat Day Hospital to which they are admitted against the advice of the Attending Medical Practitioner:
    a. A notation of the incident must be made in the patient's medical record, using 'discharged against advice' documentation.
147. In the event of a patient's death:
    a. The death must be confirmed and recorded by the Attending Medical Practitioner or their approved delegate as soon as possible;
    b. The policies for the release of cadavers from the Montserrat Day Hospital where the patient died must conform to local government and state government laws applicable to the jurisdiction of that hospital.
148. Accredited Health Practitioners must comply with:
    a. Montserrat Day Hospital 'Correct Patient, Correct Procedure, Correct Site';
    b. "Surgical Time Out"; and
    c. The Royal Australasian College of Surgeons policy entitled 'Surgical Safety Checklist'.

Surgical Assistants

149. A Medical Practitioner accredited as a surgical assistant:
    a. Cannot admit a Patient;
    b. Must practise under the supervision of the admitting Medical Practitioner;
    c. May assist in theatre and visit a patient;
    d. May examine a patient's medical records;
    e. Cannot initiate or change a treatment order relating to a patient;
    f. May have his or her Scope of Practice limited to a particular specialty or surgeon.
    g. May not:
        i. Assume or be assigned the care of a patient in place of another Medical Practitioner;
        ii. Prescribe medication for a patient;
        iii. Complete or witness consent for procedures.
150. The admitting Medical Practitioner must maintain responsibility for the completion of intraoperative records at all times.

Section 9

ADDITIONAL RULES, POLICIES AND PROCEDURES

ADDITIONAL RULES, POLICIES AND PROCEDURES

151. Subject to Clause 153, the CEO of a Montserrat Day Hospital may, acting on the advice of the MAC of that hospital, develop and implement at the hospital any rules, policies or procedures the CEO considers necessary or desirable to improve:
    a. The quality of care provided to patients;
    b. The safety of patients, Accredited Health Practitioners, Other Health Practitioners, staff and/or all other people working at or engaged by the hospital.
152. The CEO must not make any rule, policy or procedure that is inconsistent with these By-Laws.
153. The Board of Montserrat Day Hospitals endorses and encourages the CEO to develop and implement rules, policies and procedures further to Clause 152.

Section 10

CONFIDENTIALITY

CONFIDENTIALITY

General

154. Montserrat Day Hospitals and their Accredited Medical Practitioners manage all matters related to the confidentiality of information in compliance with the 'National Privacy Principles' set out in Schedule 3 of the *Privacy Act 1988* (Cth), with particular attention to sub-clauses 10.2 to 10.4 inclusive of Schedule 3 which contemplate the collection and handling of sensitive information and health information.

What Accredited Health Practitioners must keep confidential

155. Subject to Clause 158 of these By-Laws, every Accredited Health Practitioner must keep confidential the following information:
    a. Business information concerning any and all Montserrat Day Hospitals;
    b. The particulars of these By-Laws;
    c. Information concerning the insurance arrangements of any Montserrat Day Hospitals;
    d. Information concerning any patient;
    e. Any information gained by or conveyed to the Accredited Health Practitioner in the course of quality assurance activities of the Montserrat Day Hospital in respect of which he or she is accredited.

What Montserrat Day Hospital must keep confidential

156. Subject to Clause 158 of these By-Laws, Montserrat Day Hospital's must keep confidential the following information:
    a. Information supplied to Montserrat Day Hospitals by an Accredited Health Practitioner or some other person for the purpose of Accreditation;
    b. Information concerning an Accredited Medical Practitioner's business;
    c. Information concerning an adverse medical outcome with respect to an Accredited Medical Practitioner.

When confidentiality can be breached

157. The confidentiality requirements of Clauses 155 and 156 of these By-Laws do not apply in the following circumstances:
    a. Where disclosure is required by law;
    b. Where disclosure is required by a regulatory body in connection with the Accredited Health Practitioner or Montserrat Day Hospital's;
    c. Where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or
    d. Where disclosure is required in order to perform some requirement of these By-Laws.

What confidentiality means

158. The confidentiality requirements of Clauses 154 and 155 of these By-Laws prohibit the recipient of the confidential information from using it, copying it, disclosing it to someone else, reproducing it or making it public.

Confidentiality obligations continue

159. The confidentiality requirements of these By-Laws continue with full force and effect after the Accredited Medical Practitioner ceases to be accredited with respect to any Montserrat Day Hospitals.

Section 11

ADMINISTRATIVE MATTERS

ADMINISTRATIVE MATTERS

FORMS AND PAPERWORK

CEO may prescribe forms and paperwork

160. A CEO may prescribe forms (written or electronic) and other administrative processes to be completed and performed by an Accredited Health Practitioner in the treatment of a patient in connection with the patient's admission to or treatment at a Montserrat Day Hospital.
161. An Accredited Medical Practitioner must accurately complete those forms and perform those processes and then deal with them in accordance with the CEO's prescription.

Medical Advisory Committee

Term of Office

162. Members of a MAC will be appointed for a term of two (2) years.
163. An individual can be appointed for multiple and successive terms on a MAC.
164. The MAC must consist of representatives from each Major Specialty and Service provided by the hospital (representative members) and must also include the CEO and Director of Clinical Services.
165. In the State of Queensland, the MAC and its Credentials Committee must consist of 4 persons to achieve a quorum, or more persons if the CEO of the hospital so determines.
166. In the State of Queensland, the Credentials Committee of the MAC must include as an ex officio member the Director of Clinical Services or his/her delegate, who will contribute to achieving a quorum at meetings of the Credentials Committee of the MAC.
167. In the States of Western Australia and New South Wales, the MAC and its Credentials Committee must consist of a minimum of two medical practitioners and a senior organisational representative.

Electing Members

168. The representative members of a MAC are to be elected by and from among those Medical Practitioners who have been accredited by the Hospital.
169. The members of each Major Specialty and Service will elect a representative of that Major Specialty and Service to membership of the MAC.
170. Where a member of a Major Speciality is unable to be elected, the CEO may co-opt an external specialist who will not have voting power.
171. Every two years, prior to the meeting of the MAC, the CEO will call for nominations for election to the MAC.
172. Each nomination requires a proposer and a seconder and confirmation from the nominee of acceptance of nomination.
173. Voting for representative members of a MAC:
    a. Is to be done at the annual meeting of the MAC;

b. Must be done in person, with no entitlement to appoint a proxy;
c. Will be decided by a show of hands or, at the discretion of the Chair of the MAC, a secret ballot.

Chair

174. The representative members of a MAC must elect a Chair from amongst their members.

Frequency of MAC Meetings

175. The CEO will determine the time and place of 'Ordinary Meetings'.
176. There must be no less than three (3) ordinary meetings per annum in the State of Queensland, and no less than two (2) ordinary meetings per annum in the States of Western Australia and New South Wales.
177. Subject to the approval of the CEO, the Chair of its MAC may hold a 'Special Meeting'.
178. Unless at least 50% of the members of the MAC agreed to shorter notice:
    a. Ordinary meetings require not less than 14 days' prior notice to the members of the MAC; and
    b. Special meetings require not less than 7 days' prior notice to the members of the MAC.

Resignation

179. Pending the next annual meeting of the MAC, the CEO may appoint a Medical Practitioner who has been accredited at that hospital to replace any representative member of the MAC who has resigned or is indefinitely unable to continue in the role.
180. The appointee must belong to the same major specialty or service as the representative being replaced.

Additional Administration of the MAC

181. In consultation with the Chairman of the Company, the CEO may create additional rules for the proper administration of that MAC.

Section 12

APPLICATION FORMS

(Return to the Credentialing Officer, Montserrat Day Hospitals)

Applicant Details			
Title	Doctor _ Professor _ Mr _ Ms _ Mrs _ Other _		
Surname:		Given Name/s:	
Previous Name:	Please include your previous (or maiden) name that appears on birth certificate or APHRA		
Date of Birth:		Place of Birth:	
Professional Address:			
Intended First List Date:			
Associated Organisation or practice:			

Telephone Numbers: (Please provide at least two telephone numbers)

Business:		Private:	
Mobile:		Fax:	
Email Address:			
Website:			
Postal Address (If different to Professional Address)			
Private Address:			
Preferred method of correspondence:	Email _ Postal Address _ Private Address _		

Emergency Contact - in the event I am unable to be contacted for a clinical emergency

*Person nominated must be appropriately **qualified**, **registered** (APHRA) and **insured**.*

Name:		Phone:	

Nominated Sites: *Please indicate the site/s you are seeking clinical privileges for*

Sunshine Coast ☐ **Indooroopilly** ☐ **Gaythorne** ☐ **Northlakes** ☐

Australian Residency: Australian citizen _ Permanent resident _ Temporary resident _

Qualifications	*University/Organisation*	*Country*	*Year Attained*

Please refer to CV for supporting information or documentation _

Appointments/Education

Previous Clinical Appointments (list chronologically – attach separate list if insufficient space)

Appointment	*Organisation*	*Country*	*Dates (approx.)*

Please refer to CV for supporting information or documentation _

Lifetime Registration History (list chronologically – attach separate list if insufficient space)

Registration Authority	*Dates Registered*	*Country*	*Conditions or sanctions*

Are there any current sanctions/restrictions imposed on your Medical Registration? YES _ NO _

Current Clinical Appointment/s (List appointments that would continue concurrently at other private or public health care facilities, including time commitments)

Appointment	*Scope of Practice*	*Organisation*	*Time Commitment*

Academic Appointments (attach separate list if insufficient space)

Organisation	*Status/Level*	*Term of Appointment*

Continuing Medical Education

College/Organisation	*Program*	*Date Completed/Currently Enrolled*

Indemnity Insurance

Medical Indemnity Insurance]: Do you have current Medical Indemnity Insurance at the appropriate level? YES _ NO _

Insurance Company ____________________ _______ Expiry Date ___________

Scope of Practice ____

Please Note: If you are insured with ***Avant***, please find attached at the back of this application, Authority for Montserrat Day Hospitals to obtain your insurance information for the next 3 years.

References

Please list the names and contact details of at least 3 professional referees who can comment on your skills and work ethic in the areas for which you are seeking clinical privileges.

1.

Name:			
Current Position:			
Associated Organisation:			
Business Phone No:		Or Mobile Phone No:	
Email Address:			

2.

Name:			
Current Position:			
Associated Organisation:			
Business Phone No:		Or Mobile Phone No:	
Email Address:			

3.

Name:			
Current Position:			
Associated Organisation:			
Business Phone No:		Or Mobile Phone No:	
Email Address:			

Specialist Clinical Privileges

Specialist Clinical Privileges sought in the field/s of: Clinical Area and Scope of Practice for Application

Anaesthesia _ Adults _ Paediatric* **Please attach evidence of training and currency of practice.* *How many lists performed in the past 12 months: _____*	**IVF, Obstetrics & Gynaecology** _ Gynaecology _ Uro-gynaecology _ IVF _ Other (Please detail)	**Gastroenterology**** _ Gastroenterology _ Colonoscopy _ Other (please detail) *** Must have Conjoint Committee Certification – Please attach*
Dental _ General Dental _ Paediatric	**ENT** _ Adult _ Paediatric	**Urology** _ Adult
Pathology _ Clinical Haematology (please detail)	**General Surgery** _ Adult _ Paediatric _ Other (please detail)	**Orthopaedics** _ Adult _ Paediatric
Plastic and Reconstructive* Surgery _ Adult _ Paediatric ** Please specify level of procedures and attach evidence of competency*	**Cosmetic Surgery*** _ Adults	**Dermatology** _ Adult _ Paediatric
Ophthalmology _ Adult _ Paediatric	**Medical Oncology** _ Adult **Please specify level of procedures and attach evidence of competency*	_ **Other** **(Please specify)**

Categories:

Specialist Practitioner _ Dentist _ Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Privileges:

Consulting _ Assist _ Anaesthetic _ Surgical _ Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Applicant Declaration		
*I declare that all the following statements are **TRUE** or **FALSE** as indicated in the tick boxes. Please tick (_)*	**TRUE**	**FALSE**
I have never been subject to an adverse finding or had conditions or undertakings attached to my registration and I am not currently under investigation. This may include breach of insurance / medical laws, professional misconduct, sexual assaults or assault by the Health Insurance Commission, a Medical Board, a Health Care Complaints Commission/Body, a Coroner, a Court	⌟	⌟
My right to practise and/or scope of clinical practice is not under investigation and/or has never been denied, restricted, suspended, terminated or otherwise modified in or by any other health care organisation (including overseas organisations, health facilities, learned colleges or other official bodies	⌟	⌟
I am not and have never been the subject of investigation by the Health Rights Commission (HRC), Health Quality Complaints Commission (HQCC) or other similar body interstate or overseas.	⌟	⌟
A Medical Defence Union or Fund has never refused to renew my membership.	⌟	⌟
I have not been subject to criminal investigation or conviction	⌟	⌟
My clinical work is assessed by quality assurance mechanisms including clinical audit and peer review processes. I am not aware of any data from patient records, clinical audit, peer review processes or quality activities which reflects	⌟	⌟
I participate in the continuing medical education program, maintenance of professional standards program, or similar, of my College or Society and I am current with the requirements of that program.	⌟	⌟
I agree to abide by the Policies and Standards of Montserrat Day Hospitals in regards to Privacy, Informed Consent (Financial and Clinical) and Open Disclosure.	⌟	⌟
I have no physical or other conditions or substance abuse that may limit my ability to exercise the scope of practice which has been granted/requested	⌟	⌟
I do not have any criminal charges pending against me.	⌟	⌟
I have not been convicted of a criminal offence.	⌟	⌟
I have never been convicted of a drug or alcohol related offence.	⌟	⌟

Please comment below if you are unable to answer "True" to any of the above questions, and attach any relevant documentation.

_____

_____

_____

Statement of Acceptance

I, ... authorise Montserrat Day Hospitals to obtain information on an annual basis form the registration body as nominated in this application, regarding currency of my registration with that body or organisation. I will ensure that Montserrat Day Hospitals is provided with current and valid evidence of membership with an Indemnity insurance organisation.

I authorise Montserrat Day Hospitals to contact my medical defence organisation/insurer to verify that I maintain appropriate medical indemnity coverage for privileges sought.

I authorise, if applicable, Montserrat Day Hospitals to request a criminal history check be carried out on me.

I declare that the statements contained in this application are correct. In applying for appointment I agree to abide by Montserrat Day Hospital's policies and regulations and any terms or conditions which are attached to my appointment by the credentialing committee.

I undertake to immediately notify the Chair of Credentialing Committee of any material changes to the information provided by me in connection with this application, as soon as possible after the change, and particularly if my clinical Privileges are retracted, withdrawn or altered at any other hospital or day procedure facility.

I authorise Montserrat Day Hospitals, its officers and agents to seek information as to my past experience, performance and current fitness and the validity of my responses to the above questions.

I understand that I will be granted Interim Clinical Privileges until I receive notification of Full Privileges following the next Credentialing Committee Meeting.

I am aware that I will have to complete a renewal of Clinical Privileges form when notified of the expiry of my privileges at Montserrat Day Hospitals.

I understand that if I have provided misleading or deceptive information of information which is likely to mislead or deceive, that the Montserrat Board may (at its absolute discretion) consider that I do not have 'current fitness' under the Hospital By-Laws.

I acknowledge that I have been provided with, and read a copy of the Hospital By-Laws. If appointed I agree to abide by the policies, procedures of the Hospital By-Laws

Signed:.....

Date: .....

Witness Signature: .....

Witness Name: ..... (Please use block letters)

Applicant Checklist

Please ensure that all items are included in/with your application

_ Curriculum Vitae

_ required evidence of competency (as indicated in privileges sought)

_ Documentation in relation to "FALSE" answers in the 'Applicant's Declaration' (Pages 4 & 5)

_ Evidence of current Indemnity Insurance membership

_ Contact details of at least 3 referees

_ Applicants Declaration

_ Signed and Witnessed Statement of Acceptance

OFFICE USE ONLY

Applicant Name: .....

Discipline: ..... Scope of Practice: .....

Checked (☐)

1. Contact details provided _
2. CV _
3. Qualifications _
4. Training and experience _
5. Clinical appointments _
6. Continuing medical education/professional development _
7. Medical Indemnity Insurance (Evidence provided) _
8. Documentation in relation to "FALSE" answers in the Declaration. _
9. Provider Number (if applicable) _
10. Specialist status _
11. Referees _
12. Peer review _
13. Google search completed; Surname, First name, Disciplinary action _
14. Declaration signed _
15. Statement of Acceptance signed _
16. Other comments

.....

.....

.....

OFFICE USE ONLY

Applicant's details checked by (name) .....

Signature ..... Date:.....

Reference Checked by (name) .....

Signature ..... Date:.....

Please note: the CEO (or his delegate) only, may confirm granted Interim Privileges

Peer Review Conducted by (name): ..... Specialty: .....

Signature ..... Date:.....

Peer Review Recommendation: Approved _ Rejected _

Comments: .....

.....

Recommendation of Credentialing Committee at its meeting on (date) .....

Application: Endorsed _ NOT Endorsed _

If Application rejected, detail reasons:

.....

.....

.....

Endorsement/Approval of Credentialing by Board at its meeting on (date)……

Letter to applicant advising outcome of application **YES** _

Copy provided in electronic file **YES** _

SharePoint updated with Doctor credentialing, insurance and registration details **YES** _