# Mildura Health Private Hospital

## By-Laws

These By-Laws are made by the Board of Directors of Mildura District Hospital Fund Limited, trading as Mildura Health Private Hospital.

These By-Laws were adopted by the Board of Directors on 25 May 2023 and commence on 26 May 2023

**Mildura Health Private Hospital, 220-228 Thirteenth Street, Mildura Victoria 3500**

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**FOREWORD**

These By-Laws incorporate operational processes relevant to the Mildura District Hospital Fund, trading as Mildura Health Private Hospital. Compliance with these By-Laws and the Accreditation Guidelines is a condition of appointment for all Accredited Practitioners. These By-Laws apply to all Accredited Practitioners appointed to Hospitals operated by the Mildura Health Private Hospital, including Accredited Practitioners who provide services:

- to a Hospital, or
- from premises owned and/or leased by a Hospital (where Mildura Health Private Hospital has entered into a lease with the practitioner e.g. for consulting rooms), or
- in a satellite clinic established by Mildura District Hospital Fund, or
- on behalf of a contracted service provider (such as a radiology or pathology provider).

In the event of inconsistency between the Guidelines and these By-Laws, these By-Laws will prevail.

The Board of Directors may, in its discretion, establish committees however named to advise it and may establish a Medical Advisory Committee to advise it on medical matters pertaining to the Mildura Health Private Hospital.

Participants in committees established under these By-Laws should be aware of the provisions of these By-Laws which concern confidentiality of the proceedings of those committees, and the requirement to avoid and declare conflicts of interest.

Private hospitals and medical practitioners are subject to the processes and requirements of the Competition and Consumer Act 2010 (formerly known as the Trade Practices Act 1974) and competition law. Appropriate attention to the processes contained in the By-Laws will assist all involved in satisfying these legal requirements.

These By-Laws are made by the Board of Directors of the Mildura District Hospital Fund Limited.

Board of Directors Chairperson

## MILDURA DISTRICT HOSPITAL FUND BY-LAWS

## PART A – INTERPRETATION AND GENERAL PROVISIONS

### 1. COMMENCEMENT

These By-Laws shall commence on 26 May 2023 On commencement, these By-Laws repeal and replace the By-Laws dated 1 April 2020.

### 2. INTERPRETATION

### 2.1. Definitions

In these By-Laws, unless the context otherwise requires:

**Accreditation** means the authorisation in writing by the Chief Executive Officer or an approved delegate for a Health Practitioner to treat patients at the Mildura Health Private Hospital within the Clinical Privileges and in accordance with the conditions specific in that authorisation, and the processes that are described in these By-Laws leading to that authorisation.

**Accreditation Guidelines** means the guidelines attached or as promulgated by the Board from time to time specifying the category of Accreditation to be assigned to accredited practitioners at Mildura Health Private Hospital pursuant to By-Law 8.

**Accredited Practitioner** means a Medical Practitioner or Dentist appointed by the Mildura District Hospital Fund and granted Clinical Privileges. Appointment as an Accredited Practitioner under these By-Laws is a prerequisite to practice at a Hospital.

**AHPRA** means The Australian Health Practitioner Regulation Agency (AHPRA) which is the organisation responsible for the registration and accreditation of health professions across Australia.

**Appeals Committee** comprises a majority of medical practitioners from a range of disciplines who have the necessary skills and experience to provide informed and independent advice, and include at least one medical practitioner or dentist who practices in the field relevant to clinical scope being reviewed. The committee is to include a nominee of the relevant college and a nominee (medical practitioner or dentist) of the person who is the subject of the appeal.

**Board of Directors** means the Board of Directors of the Mildura District Hospital Fund.

**By-Laws** means these By-Laws.

**Career Medical Officer** means an employed doctor or staff medical officer who provides medical services to inpatients but whose employment may or may not necessarily be part of a specialist training program.

**Chief Executive Officer** (Mildura Health Private Hospital) means the person appointed to that position by the Board of Directors, or his or her delegate (where applicable) by whatever name he or she is known.

**Clinical Privileges** means the specific medical services or procedures permitted to be undertaken by an Accredited Practitioner.

**Credentialing** means the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of a Health Practitioner 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 and confidence held in that Health Practitioner and training and experience that contribute to a Health Practitioners competence, performance and professional suitability to provide safe, high quality health care services. For the purposes of these By-Laws, a Health 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 Mildura Health Private Hospital policy and procedures are also regarded as relevant to their credentials.

**Current Fitness** is the current fitness required of an applicant (Accredited Practitioner), to carry out the clinical privileges sought or currently held. 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 medicine and carry out the Clinical Privileges sought or granted. Intoxication by alcohol or drugs at the Mildura Health Private Hospital is considered to be a physical or mental disorder which if in place would warrant immediate cessation of duties.

**Director of Clinical Services (DCS)** means the nursing practitioner with appropriate qualifications appointed to that position by the Board of Directors.

**Director Medical Services (DMS**) means the medical practitioner with appropriate qualifications appointed to that position by the Board of Directors. The appointment

may be sessional, permanent part time or permanent full time depending on requirements.

**Doctor-in-training** means a junior medical practitioner and includes an intern, a resident, a registrar, a provisional fellow and may include a surgical assistant.

**Fellow** is either a graduate of an Australian Medical School who has completed specialist training or a graduate of a foreign medical school who has successfully met the criteria for fellowship of the applicable college who is appointed to Mildura Health Private Hospital.

**Governing body** means the Board of Directors.

**Hospital** means any hospital owned or operated by Mildura District Hospital Fund.

**Hospital** includes:

(a) Mildura Health Private Hospital, or

(b) any other hospital owned or operated by the Mildura District Hospital Fund from time to time.

**Hospital Executive Group** consists of the Chief Executive Officer, the Director of Clinical Services, Finance Manager and the Director of Medical Services.

**Intensive Care Medical Officer** means an anaesthetist with appropriate qualifications/experience who provides medical services to inpatients including intensive care patients but whose employment is not necessarily part of a specialist training program.

**Medical Advisory Committee (MAC)** means a medical advisory committee of a Hospital established under By-Law 20.

**Medical Board of Australia** means the Medical Board of Australia established under the Health Practitioner Regulation National Law (Victoria) Act 2009.

**Credentialing Application Form** means the application form approved by the Mildura District Hospital Fund from time to time for use by a Medical Practitioner or Dentist to apply to become an Accredited Practitioner with Clinical Privileges at the Hospital.

**Mildura District Hospital Fund** means the body corporate known as the Mildura District Hospital Fund Limited.

**Medical Practitioner** means a person who is registered under the Health Practitioner Regulation National Law (Victoria) Act 2009 in the medical profession.

**Oral and Maxillofacial Surgeon** means a person recognised as a Specialist Practitioner in the category of Oral and Maxillofacial Surgery for the purpose of the Health Insurance Act 1973 (Commonwealth).

**Private Hospital Committee** means the Committee established by the Board of Directors.

**Regulation** means a regulation made under the Act.

**Specialist 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).

**Staff Specialist** means a Specialist Practitioner employed by the Mildura District Hospital Fund.

**Surgical Assistant** means a medical practitioner who is accredited for the purposes of assisting a surgeon.

## 2.2. General Interpretation

(a) Rules for interpreting this document

In these By-Laws headings are for convenience only and do not affect interpretation.

The following rules also apply in interpreting these By-Laws, except where the context makes it clear that a rule is not intended to apply:

(i) A reference to legislation (including subordinate legislation) is to that legislation as amended, re-enacted or replaced, and includes any subordinate legislation issued under it.
(ii) A reference to a document or agreement, or a provision of a document or agreement, is to that document, agreement or provision as amended, supplemented, replaced or novated.
(iii) A singular word includes the plural, and vice versa.
(iv) A word which suggests one gender includes the other gender.
(v) If a word is defined, another part of speech has a corresponding meaning.

(vi) If an example is given of something (including a right, obligation or concept), such as by saying it includes something else, the example does not limit the scope of that thing.

(b) Title

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

(c) Quorum

Where a reference is made to a meeting and no quorum is specified, the following quorum requirements shall apply:

(i) where there is an odd number of members of the committee or group, a majority of the members; or
(ii) where there is an even number of members of the committee or group, one half of the number of the members plus one, unless otherwise specified by the Board of Directors.
(iii) failure to achieve a quorum disallows members to vote or endorse any agenda items.

(d) Resolutions without meetings

A decision may be made by a committee established by the Board of Directors or pursuant to these By-Laws without a meeting if a consent in writing setting forth such a decision is signed by all the committee or group members, as the case may be.

(e) Meeting by electronic means

A committee established by the Board of Directors or pursuant to these By-Laws may hold any meeting by electronic means whereby participants can be heard and can hear but are not necessarily in the same place. The requirements of these By-Laws shall nonetheless apply to such a meeting.

(f) Confidentiality

Information provided to any committee, or person which is provided in confidence shall be regarded as confidential and is not to be disclosed to any third party or beyond the particular forum for purposes which such information is made available save for disclosure of notifiable conduct as required by law.

(g) Voting

Where required by these By-Laws, voting shall be on a simple majority voting basis and only by those in attendance at the meeting. There shall be no proxy vote. In the event of an equality of votes the Chairperson shall have an additional vote.

## 3. BOARD OF DIRECTORS (BOD)

The Board has the authority on behalf of Mildura District Hospital Fund to make By-Laws, rules and policies for the operation of the Mildura Health Private Hospital as it may deem necessary from time to time.

## 4. DISPUTES

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

## 5. REVISION

The Board of Directors may after due consultation from time to time make, vary or revoke these By-Laws but they shall be reviewed at least every three years after due consultation with the Medical Advisory Committee.

## PART B – APPOINTMENT OF ACCREDITED PRACTITIONERS

### 6. RIGHT TO PRACTICE

A Practitioner may not practice at the Mildura Health Private Hospital unless he or she is appointed as an Accredited Practitioner at that Hospital.

An Accredited Practitioner may only exercise those Clinical Privileges specifically granted to that Accredited Practitioner at that Hospital and contained in the Accreditation Guidelines.

### 7. CONFIDENTIALITY

The proceedings involved in granting accreditation and Clinical Privileges to an Accredited Practitioner are confidential and not to be disclosed outside the particular committee responsible for these functions in accordance with these By-Laws. Such confidentiality provisions shall also apply to any confidential information and to any committee or sub-committee of the Hospital.

### 8. CATEGORIES OF ACCREDITED PRACTITIONERS

(a) Each person appointed as an Accredited Practitioner to the Hospital shall be appointed to one or more of the following categories:

 (i) Visiting Medical Officer (VMO)
 (ii) Visiting Dental Practitioner
 (iii) Staff Specialist.

(b) A Medical Practitioner who provides medical services to the Hospital or a satellite clinic on behalf of a contracted service provider (such as a radiology or pathology provider), must be appointed as an Accredited Practitioner.

### 9. FORMS OF ACCREDITATION

The Medical Advisory Committee may recommend and the Board of Directors may grant any of the following forms of accreditation:

(a) Temporary Accreditation as referred to in By-Law 9.2 or

(b) Full Accreditation as referred to in By-Law 9.3.

## 9.2. Temporary Accreditation

The following applies to Temporary Accreditation:

(a) Temporary Accreditation may be granted to a Practitioner by the Board of Directors for a period not exceeding six (6) months;

(b) Temporary Accreditation ceases upon the expiration of the period for which it is granted or on the date upon which the Board of Directors informs the applicant of the decision made in respect of the applicant's application for full accreditation;

(c) The period of temporary accreditation may be extended beyond six (6) months for up to a further six (6) months by the Board of Directors where the Medical Advisory Committee or Board of Directors has not had sufficient opportunity within that period in which to make a decision regarding the application or wishes to defer any decision so as to allow the applicant further time in which to satisfy it on any matter or thing concerning that application.

The Board of Directors may during the Period of Temporary Accreditation of a Practitioner suspend or terminate the Temporary Accreditation of that Practitioner without being obliged to assign or provide any reason for so doing.

No right of appeal arises from a decision to suspend or terminate the Temporary Accreditation of a medical practitioner.

## 9.3. Full Accreditation

The following applies to Full Accreditation:

(a) Full Accreditation may be granted to a Practitioner by the Board of Directors having regard to the recommendation of the Medical Advisory Committee.

(b) Full accreditation may be granted for a period not exceeding three (3) years.

(c) Full Accreditation ceases upon the expiration of the period for which it is granted.

## 10. PROCESS OF APPLICATION FOR PRIVILEGES, APPOINTMENT AND REAPPOINTMENT

### 10.1. Application requirements

The DMS or DCS shall provide each practitioner seeking appointment with a Credentialing Application Form that a practitioner must submit when seeking appointment as an Accredited Practitioner and make available a copy of the By-Laws.

(a) A practitioner seeking appointment as an Accredited Practitioner shall complete a Credentialing Application Form and provide such a form to the Director of Clinical Services together with copies of the following:

(i) Certified copies of proof of identity based on a 100-point check
(ii) National police history check
(iii) International police check if the applicant has lived overseas for 12 months or longer during the past 10 years
(iv) Working with Children Check
(v) Certified copies of primary medical degree and specialist qualifications
(vi) Copy of procedural qualifications (where applicable)
(vii) Copies of medical registration and medical indemnity insurance
(viii) CPD college certificate or evidence of relevant CPD
(ix) Current Curriculum Vitae
(x) At least two written references from medical practitioners in the same craft group/specialty as the applicant who can attest to:

(A) the experience and performance of the applicant in that area of specialty during the previous three years
(B) have no conflict of interest in providing a reference,
(C) whether they are aware of any reason why the applicant should not be recommended for appointment.

Practitioners with additional specialist qualifications must also provide evidence of such qualifications e.g. Joint Consultative Committee on Anaesthesia (JCCA), DRANZCOG, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE).

(b) A practitioner seeking appointment will, if requested, also provide Mildura District Health Fund with a completed Privacy Act release in the form required by Mildura District Health Fund as part of the application and to allow consideration by the Medical Advisory Committee as to the training,

experience, competence, judgement, professional capabilities and knowledge, current fitness, character and confidence held in the applicant.

(c) There is no obligation on the Mildura District Health Fund to process or consider an incomplete Medical Credentialing Application Form.

(d) If an applicant presents an incomplete Credentialing Application Form the Hospital Executive Group (HEG) will advise the applicant that the application is incomplete and of the outstanding requirements. If the applicant does not complete the application requirements within 30 days, or such later period as allowed (in writing) by the HEG the application will be deemed to have been withdrawn.

### 10.2. Consideration of application

Following receipt of a completed Credentialing Application Form:

(a) The Medical Advisory Committee (MAC) shall review the application and satisfy itself as to the training, experience, competence, judgement, professional capabilities and knowledge, current fitness, character and confidence held in the applicant and make recommendations as to the delineation of clinical privileges and make recommendations in respect to the application to the Board of Directors.

(b) The recommendation of the MAC may include conditions on both appointment and reappointment including, without limitation, a requirement that an Accredited Practitioner (such as a newly qualified Specialist Practitioner) participate in a formal mentoring and/or supervision program and comply with any requirements with respect to minimum procedural throughput, including a requirement to demonstrate performance of a designated number of procedures within a designated period.

(c) The BOD shall make a final determination as to the application.

(d) Notwithstanding the recommendation of the MAC the BOD may refuse to appoint or reappoint an applicant, either on operational, commercial or strategic grounds taking into account, but not limited to the following considerations:

(i) The strategic plans of the Mildura District Hospital Fund.
(ii) The resources available to the Mildura District Hospital Fund.
(iii) The profitability of procedures for the Mildura District Hospital Fund.

(iv) Health service areas and mix of health service areas that the Mildura District Hospital Fund has chosen or may wish to pursue.

## 10.3. Notification of decision

(a) The Board of Directors shall consider the recommendation of the Medical Advisory Committee as to whether a Practitioner shall be granted Temporary Accreditation or Full Accreditation (including the period for which Full Accreditation is granted) or whether a Practitioner holding Temporary Accreditation shall be suspended or terminated.

(b) The Chief Executive Officer shall notify the applicant in writing of the decision within 14 days after the Board of Directors makes its determination.

(c) The Board of Directors is not required to give;

(i) to an applicant for Temporary Accreditation any reason for the refusal of that applicant’s application; or

(ii) to any applicant to whom Full Accreditation is not granted any reason for that Practitioner not being granted Full Accreditation; or

(iii) to any Practitioner whose Temporary Accreditation is not granted or is terminated any reason for that Practitioner not being granted Full Accreditation or for his or her Temporary Accreditation being suspended or terminated.

## 10.4. Applications for reappointment for Full Accreditation

(a) The HEG shall at least ninety days prior to the expiration of an Accredited Practitioners’ term of appointment for Full Accreditation, provide that Accredited Practitioner with a Credentialing Application Form.

(b) Where a medical practitioner applies for reappointment consequent upon expiry of the term of appointment granted under By Law 10.3 it shall be the responsibility of the Accredited Practitioner to provide the completed Medical Credentialing Application Form to the HEG with the following supporting documentation:

(i) Copies of medical registration and medical indemnity insurance

(ii) CPD college certificate or evidence of relevant CPD

(iii) Updated Curriculum Vitae

(iv) Copy of current Working with Children Check.

(c) On completion of a 3-year term an Accredited Practitioner performance review must occur before recredentialing can be processed.

(d) An application for reappointment will be considered in accordance with By-Law 10.2 and the outcome communicated in accordance with By-Law 10.5.

(e) Where the application for reaccreditation is unsuccessful or the Clinical Privileges are altered the applicant Accredited Practitioner must be provided with written reasons as to why the application was unsuccessful or the Clinical Privileges altered.

**10.5. Notification of decision regarding reappointment**

(a) The Board of Directors shall consider the recommendation of the Medical Advisory Committee as to whether a Practitioner shall be granted a further term of Full Accreditation with the same Clinical Privileges, whether the Clinical Privileges should be altered either to the benefit or detriment of the Accredited Practitioner or whether the application for reaccreditation should be rejected or refused.

(b) The Chief Executive Officer shall notify the applicant in writing of the decision within 14 days after the Board of Directors makes its determination.

(c) Where the decision is adverse to the applicant the Board of Directors must provide the applicant with written reasons for;

(i) the refusal of that applicant's application; or
(ii) the restriction or alteration of the Clinical Privileges.

An Accredited Practitioner has a right of appeal arising from any decision under By-Law 10.5.

**10.6. Lapse of Accreditation**

Where an Accredited Practitioner does not seek reappointment prior to the expiration of the Accredited Practitioners' period of accreditation that Accredited Practitioner's accreditation will lapse on the last day of the period for which that Accredited Practitioner has been accredited. A Practitioner is not entitled to admit patients to the Hospital or to perform any clinical functions at that Hospital after his or her accreditation has lapsed.

### 10.7. Application to amend Clinical Privileges

(a) Any Accredited Practitioner, at any time, may make application in writing for amendment of his or her Clinical Privileges.

(b) Any application from a General Practitioner to amend his or her Clinical Privileges must include evidence of the specific course or training undertaking, the experience gained, the organisation offering the course and the qualifications gained.

(c) Any application from a Specialist Practitioner to amend his or her Clinical Privileges must include evidence of the relevant clinical experience and post-graduate training. This application must be accompanied by a reference from a person who has the ability and qualifications to judge the applicant's performance and ability to satisfy the requirements of the new Clinical Privileges.

(d) The DMS/DCS along with the head of the area of specialty shall give such application appropriate consideration and make a recommendation to the Medical Advisory Committee as to the amendments sought.

(e) The Medical Advisory Committee shall give such application appropriate consideration and make a recommendation to the Board of Directors as to the amendments sought.

(f) The Board of Directors shall then consider the relevant recommendations concerning the application.

(g) The Chief Executive Officer shall advise the Accredited Practitioner of the Board of Directors decision within 14 days.

## 11. TERMS AND CONDITIONS OF APPOINTMENT

Appointment of an Accredited Practitioner shall be conditional upon the practitioner;

(a) acting in accordance with the Accreditation Guidelines;

(b) acting in the best interests of patients and Mildura District Hospital Fund by working with Mildura Health Private Hospital staff to ensure the efficient use of resources, including facilities and theatres, in order to reduce waiting times and produce timely admissions;

(c) demonstrating a commitment to Mildura District Hospital Fund by giving an estimate of proposed procedures and consultations, agreeing to regularly attend relevant clinical meetings, seminars and lectures;

(d) participating in Mildura Health Private Hospital's clinical audits and Mildura Health Private Hospital committees;

(e) participating in training teaching and research activities as may be appropriate;

(f) complying with any conditions of accreditation as determined by the Board of Directors including, without limitation, any requirements under By-Law 10.2(b) to participate in a mentoring and/or supervision program or with respect to procedural throughput;

(g) providing personal care (or making adequate provision for an accredited practitioner to act on his/her behalf) in accordance with the Rules and Regulations as set out by the Hospital and the Mildura District Hospital Fund;

(h) attending patients in a timely manner subject to the limits of any conditions imposed by the Board of Directors; Postoperative care must be delegated to an appropriate accredited practitioner if the specialist travels away from Mildura;

(i) taking all reasonable steps to ensure that timely adequate entries are made in the Hospital medical records and are legible and maintained for all patients under his/her care in accordance with statutory requirements and the Australian Commission on Safety and Quality in Healthcare National Safety and Quality Health Service Standards requirements and any other data reasonably required by the Hospital;

(j) observing all reasonable requests made by the Hospital with regard to personal conduct in the Hospital and with regard to the provision of services within the Hospital;

(k) adhering to the generally accepted ethics of professional practice both in relation to colleagues and to patients under his/her care;

*Note: For the avoidance of doubt, and without limiting the generality of By-Law 11(k), the Board of Directors considers the raising of fees by an Accredited Practitioner which are, in all the circumstances manifestly excessive, to be contrary to generally accepted ethics of professional practice.*

(l) ensuring that his/her patients are provided with sufficient and timely information regarding the Accredited Practitioner's potential fees (and applicable rebates) to enable the patient to make an informed financial decision regarding the services the Accredited Practitioner intends to provide (including, without limitation, complying with any applicable policies and procedures of the Mildura District Health Fund and the Hospital relating to informed financial consent);

(m) observing the general conditions of clinical practice applicable to the Hospital;

(n) participating in reasonable Hospital administrative practices in a timely manner, to enable the Hospital to collect revenues from appropriate sources, for care given;

(o) maintaining and producing on request evidence of an adequate level of professional indemnity insurance with a reputable insurer covering Clinical Privileges granted;

(p) furnishing annually to the Hospital in a Mildura District Health Fund approved format satisfactory documentary evidence of:
   (i) registration with AHPRA; and
   (ii) attainment of the continuing medical education requirements (if any) of their respective College or professional association;
   (iii) whether the right to practice at a hospital or day procedure centre has been withdrawn or restricted during the previous year and provide full details;

(q) advising the HEG promptly (or within 14 days) should:

   (i) he / she be involved in a significant adverse event or adverse finding occurring at a Hospital controlled by the Mildura District Health Fund or any other hospital or day procedure centre;
   (ii) an adverse finding (whether formal or informal) be made against him / her by AHPRA or the Medical Board of Australia (or other responsible board where applicable) or the Victorian Civil and Administrative Tribunal (VCAT);
   (iii) he / she be the subject of an investigation or an adverse finding by the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC);
   (iv) he / she is the subject of a criminal complaint, investigation or charge;
   (v) his / her professional registration be revoked, suspended or amended;
   (vi) professional indemnity insurance or membership of a medical defence organisation be made conditional or not be renewed; or

(vii) his / her appointment at any other hospital or day procedure centre be adversely altered in any way including, without limitation, the imposition of any restriction or condition on his or her appointment or scope of practice;

(r) participating in any clinical quality assurance program approved by the Medical Advisory Committee;

(s) adhering to the rules of medical practice established by the Hospital from time to time;

(t) participating in agreed formal on call arrangements as required by the Board of Directors following consultation with the Medical Advisory Committee;

(u) not representing in any way that they represent the Hospital, or the Mildura District Health Fund, in any circumstances, including the use of Hospital or Mildura District Health Fund letterhead, unless with the express written permission of the Board of Directors;

(v) being available, or deputising an appropriately qualified Accredited Practitioner to act as locum or for an emergency call to the Accredited Practitioner's patients;

(w) meeting all reasonable requests to participate in the education and training of medical and other professional nursing and technical staff of the Hospital and in the education and training of students attending the Hospital including facilitating the availability of patients for clinical teaching subject to any contrary instructions by either;

(i) the treating practitioner; or

(ii) the Director of Clinical Services,

and informed consent being given by the patient;

(x) seeking the approval of DMS/DCS in regard to any professionally recognised new or amended treatment, use of technology or procedure;

(y) regularly attend and when reasonably so required participate in such pertinent clinical meetings, seminars, lectures and other training events as may be organised and held at the Hospital;

(z) attending to patients in person with reasonable frequency including on weekends and after hours appropriate to the patient's clinical condition;

(aa) ensuring that the prescription and administration of all medication and drugs complies with applicable State and Commonwealth legislation; and

(bb) complying with the requirements of the Working With Children Act 2005 (Vic) or legislation with similar objectives applicable to medical or dental practitioners, including without limitation, advising the Hospital if they are charged with having committed or are convicted of a sex or violence offence;

(cc) providing where requested a National Criminal History check.

Mildura District Hospital Fund reserves the right to cancel the appointment of an Accredited Practitioner in the event that an Accredited Practitioner fails to maintain a commitment to regularly practice at Mildura Health Private Hospital and/or membership of and /or participation in relevant committees.

## 12. REVIEW OF CLINICAL PRIVILEGES

### 12.1. Internal Review

The Board of Directors may at any time, direct the Medical Advisory Committee through the HEG, to promptly review the Clinical Privileges previously granted to an Accredited Practitioner including an assessment if necessary, of current fitness by showing evidence of competence to practice including but not limited to ongoing medical indemnity cover and/or a medical clearance. Following such review, the HEG considering the advice of the Medical Advisory Committee, shall make a recommendation to the Board of Directors concerning the continuation, amendment, suspension or revocation of those Clinical Privileges.

Accredited Practitioners with additional Specialist qualification/s must meet the ongoing registration and professional development of the applicable college.

Special conditions may be imposed by the CEO having received the advice of the Medical Advisory Committee.

### 12.2. Independent Review

The Board of Directors may require and commission, or direct the HEG to commission an independent review of the Clinical Privileges, practice or appointment of any Accredited Practitioner. The report of such a review may include an assessment if necessary, of Current Fitness and confidence held in such an appointee and such a review may concern the continuation, amendment, suspension or revocation of Clinical Privileges. Such a review process shall result in a recommendation to the Board of

Directors who shall make a final determination in relation to the matter, subject to the provisions of By-Laws 13 & 14.

## 13. SUSPENSION OF CLINICAL PRIVILEGES

The Board of Directors and the HEG may, following consultation with the Chairperson of the Medical Advisory Committee, suspend any Accredited Practitioner if the Board of Directors reasonably believes;

(a) it is necessary for patient care or safety; or

(b) the conduct of the Accredited Practitioner appears to be such that it is unduly hindering the efficient operation of the Hospital at any time; or

(c) the conduct of the Accredited Practitioner appears to be bringing, or may bring, the Hospital into disrepute; or

(d) the behaviour or conduct of the Accredited Practitioner appears to be not consistent with the values and behaviours of the Mildura District Hospital Fund and/or the objects of the Mildura District Hospital Fund.

The Chief Executive Officer shall notify the Accredited Practitioner of the decision of the Board of Directors giving reasons why the Clinical Privileges have been suspended or terminated. Immediately upon the imposition of suspension or termination the affected practitioner will take steps, with the patients' consent to transfer the care of any patients to another appropriate Accredited Practitioner.

The affected practitioner shall have the rights of appeal established by By-Law 15.

## 14. TERMINATION OF APPOINTMENT

(a) An appointment shall be immediately terminated should an Accredited Practitioner;

  (i) cease to be registered by AHPRA or the Medical Board of Australia (or other responsible board where applicable); or
  (ii) where the Accredited Practitioner's professional indemnity insurance or membership of a medical defence fund is cancelled, lapses or no longer adequately covers the Accredited Practitioner to the extent of his or her Clinical Privileges, except where the Accredited Practitioner is an employee of the Mildura Health Private Hospital.

(b) An appointment shall be terminated should the Accredited Practitioner not be regarded by the Board of Directors as having the appropriate Current Fitness to retain the Clinical Privileges granted or the Board of Directors does not have confidence in the continued appointment of the Accredited Practitioner.

(c) An appointment may be terminated should an Accredited Practitioner become permanently incapable of performing his or her duties over a continuous period of not less than 6 months.

(d) The appointment of an Accredited Practitioner may at any time be suspended or terminated by the Board of Directors where:

(i) the Accredited Practitioner fails to observe the terms and conditions of his/her appointment as outlined in the Accreditation Guidelines; or
(ii) the Accredited Practitioner is in breach of these By-Laws; or
(iii) the Accredited Practitioner is found to have engaged in unprofessional conduct (however described) whether or not the practitioner has been prosecuted for or convicted of an offence in relation to the contravention of the Health Practitioner Regulation National Law (Victoria) Act 2009 or its predecessor Acts; or
(iv) (an independent review has been conducted of the Accredited Practitioner pursuant to By-Law 12.2 and following review of any such report of that review the Board of Directors does not have confidence in the continued appointment of the Accredited Practitioner.

(e) An Accredited Practitioner may resign his/her appointment after the expiry of one month after the giving of notice to the Hospital, unless agreed otherwise by the Board of Directors.

(f) The Board of Directors may suspend or terminate an appointment of an Accredited Practitioner should that practitioner be convicted of a sex or violence offence or any offence which affects the Accredited Practitioner's practice as a Medical Practitioner.

(g) The appointment of an Accredited Practitioner who provides services on behalf of a contracted service provider shall terminate on the expiry or termination of the agreement with the contracted service provider for whom the Accredited Practitioner provides services, or on the termination or the Accredited Practitioner's employment or engagement with the contracted service provider.

(h) No right of appeal arises where the appointment of an Accredited Practitioner is terminated in accordance with this By-Law 14(g).

## 15. RIGHT TO APPEAL

(a) There shall be no right of appeal against a decision not to make an initial appointment to the Hospital for Temporary or Full Accreditation and no new application for an initial appointment may be made until the expiration of 12 months from the date of that decision.

(b) Should an applicant holding current Full Accreditation have that appointment or an application to vary his/her accreditation rejected either in whole or in part or varied by the Board of Directors, the applicant shall have the rights of appeal set out within these By-Laws.

(c) Should an Accredited Practitioner holding a current appointment have his or her accreditation adversely affected (either by alteration, suspension or termination) by the Board of Directors, the applicant shall have the rights of appeal set out within these By-Laws.

## 16. APPEALS - FORM AND PROCEDURE

### 16.1. Lodgement of Appeal

A Practitioner (the "Appellant") who seeks to appeal any decision made under By-laws 10.5, 13 & 14 shall lodge with the Director of Clinical Services, notice of appeal against that decision within thirty (30) days of her or his receiving notice of that decision.

The Notice of Appeal shall be in writing and shall specify:

- the name of the Appellant;
- the decision being appealed; and
- the grounds of appeal.

The HEG shall refer the appeal to the Appeals Committee convened as outlined at By-Law 16.3.

### 16.2. Loss of Right of Appeal

A Practitioner who fails to comply with By-Law 16.1 shall have no right to appeal any decision made under By-Laws 10.5, 13 &14.

## 16.3. Procedure of Appeals Committee

The HEG and the Chair of the Medical Advisory Committee shall constitute and convene the Appeals Committee within twenty-one (21) days of the Notice of Appeal being lodged with the HEG.

The Appeals Committee shall commence to hear an appeal within ninety (90) days of the notice of appeal being lodged with the HEG.

The Appeals Committee may conduct its hearings and may adjourn its hearings from time to time as it considers appropriate.

The Appeals Committee shall:

(a) review all documents which it considers relevant to the Appellant's appeal;

(b) hear the Appellant and the HEG and such other persons as the Appellant and the HEG seek to have the Appeals Committee hear and whom the Appeals Committee considers may provide evidence or material relevant to the appeal;

(c) afford to the Appellant and any person nominated by the HEG every reasonable opportunity to put any argument and submission which either wishes to make, either orally or in writing;

(d) hear such other persons as the Appellant and the HEG seek to give evidence to it and whom the Appeals Committee considers may provide evidence or material relevant to the appeal;

(e) consider and make a decision upon the Appellant's appeal;

(f) as soon as practicable after reaching its decision, convey that decision and a recommendation in writing to the Board of Directors and the HEG; and

(g) the Board of Directors must make a final and binding decision on the appeal taking into consideration the recommendation of the Appeals Committee.

## 16.4. Communication of the Decision of the Board of Directors

Within seven (7) days of the decision of the Board of Directors the HEG will notify the Appellant in writing of that decision.

### 16.5. Decision Final

The decision of the Board of Directors will be final and binding on the Appellant and shall not be subject to further appeal or review by any tribunal or court of law.

## 17. APPEALS COMMITTEE

### 17.1. Constitution of Appeals Committee

The HEG shall constitute an Appeals Committee to hear that appeal. So far as the HEG considers appropriate the Appeals Committee shall include:

- the Chairperson of the Medical Advisory Committee;
- a person nominated by the Board of Directors;
- an Accredited Practitioner in the speciality in which the appellant practices, nominated by the Medical Advisory Committee; and
- such other persons as the Medical Advisory Committee considers ought to properly hear the Appellant's appeal and may include:
  - a representative of the college or body awarding qualifications in the discipline or speciality in which the Appellant practices (who may or may not be an accredited medical practitioner);
  - a representative of the State branch of the Australian Medical Association or Australian Dental Association or other body concerned with the discipline of the appellant.

### 17.2 Function of Appeals Committee

The function of the Appeals Committee shall be to hear and determine the appeal of all Practitioners against decisions to:

- refuse to renew the accreditation of an Accredited Practitioner;
- suspend or terminate the accreditation of an Accredited Practitioner; or
- restrict the right of or impose conditions on the right of an Accredited Practitioner to exercise clinical privileges within the Hospital.

### 17.3 Chair of Appeals Committee

The Chair of the Appeals Committee shall be the Chair of the Medical Advisory Committee unless a representative from the State Branch of the Australian Medical Association or the Australian Dental Association is present. In that case it is a person appointed by the chair or equivalent officer of the State branch of the Australian Medical Association or the Australian Dental Association or other body concerned with the discipline of the Appellant.

## 18 ACKNOWLEDGEMENT BY PRACTITIONER

Each Practitioner who seeks accreditation or renewal of accreditation and each Practitioner to whom accreditation or renewal of accreditation is granted acknowledges that:
firstly:

(a) the granting of accreditation and the terms and conditions upon and subject to which accreditation is granted;

(b) re-accreditation and the terms and conditions upon and subject to which accreditation is renewed;

(c) the privileges attached to accreditation and re-accreditation;

(d) the review of the terms and conditions which apply to accreditation and the privileges of accreditation; and

(e) suspension and termination of accreditation,

(f) are, in each case, within the discretion of the Hospital and Board of Directors; and

secondly, that no Practitioner has any right, interest or legitimate expectation as to any one or more of:

(a) the granting of accreditation;

(b) re-accreditation;

(c) the terms, conditions or privileges of accreditation and re-accreditation; or

(d) the maintenance or continuation of accreditation; and

thirdly, these By-laws exist for the purpose of recording the procedures that will be observed and followed by the Hospital from time to time and do not exist for the purpose of:

(a) conferring on any Practitioner or Practitioners any legally enforceable rights; or

(b) creating in any Practitioner any legitimate expectation in relation to any of the matters or things referred to in this By-law.

## 19 ANNUAL GENERAL MEETING

### 19.1 Annual General Meeting of Accredited Practitioners

(a) An Annual General meeting of accredited practitioners shall be held in March of each year.

(c) Not less than seven (7) days written notice of the Annual General meeting must be given to all Accredited Practitioners specifying the business to be transacted.

(d) The Annual General meeting shall be chaired by the current Chairperson of the Medical Advisory Committee.

(e) A constituted quorum will be per Clause 2.2 (c).

(f) The purpose of the meeting shall be the announcement of the result for election of members of the Medical Advisory Committee and to receive reports from the Chief Executive Officer, Chairperson of the Medical Advisory Committee and any other persons and committees responsible for the fulfilment of required staff functions.

(g) Other business in relation to the Medical Advisory Committee may be raised at this meeting.

(h) The accidental omission to give any notice or the non-receipt of a notice by any Accredited Practitioner shall not invalidate the proceedings of an Annual General Meeting.

### 19.2 Attendance

All Accredited Practitioners are invited to attend the Annual General Meeting.

### 19.3 Minutes

(i) Minutes of The Annual General Meeting shall be prepared by the Secretary or designate of the meeting and shall include a record of attendance and vote taken on each matter.

(ii) A permanent file of the minutes of each meeting shall be maintained.

## 20. MEDICAL ADVISORY COMMITTEE

### 20.1 Requirement for Medical Advisory Committee

There shall be a Medical Advisory Committee with a terms of reference, the purpose of which shall be to advise the Board of Directors with respect to;

(a) making clinical policy, planning and review of the clinical procedures of the Hospital;

(b) the ensuring of appropriate conditions for clinical procedures within the Hospital;

(c) the introduction of new surgical and medical procedures within the Hospital;

(d) the conduct of the process for delineation of clinical privileges;

(e) the review of matters relating to clinical practice and accreditation;

(f) quality activities and peer review programs for Accredited Practitioners;

(g) dealing with managing and prescribing the practice and behaviour of impaired and disruptive medical practitioners;

(h) these Bylaws, Rules and Regulations, Committee nominations and Medical Practitioners administration;

(i) all matters relating to safety and quality of patient care; and

(j) issues of competency of Practitioners.

### 20.2. Function and Role of Medical Advisory Committee

The Medical Advisory Committee shall;

(a) provide advice and assistance to the Board of Directors in all aspects of clinical practice, safety and quality of care;

(b) promote and participate in continuous quality improvement activities relating to clinical practice and in such programs and reviews as may be established by the Hospital as a part of its program of clinical risk management;

(c) promote and participate in the relevant Hospital Committees:

(i) to develop and maintain a system of surveillance of drug utilisation.

(ii) to monitor and review the appropriateness of the medical and other related records within the Hospital.

(iii) to review and coordinate investigations in relation to the prevention of hospital infection.

(iv) to review and evaluate the planning for fire and other disasters, meeting the needs of both the Hospital and community.

(v) to review operating room service, utilisation and administration.

(d) if requested by the Board of Directors so to do, and in consultation with the Ethics Committee (if established), or other persons nominated by the Board of Directors;

(i) review and recommend to the Ethics Committee clinical research to be undertaken; and

(ii) review the reports of indicators of care provided by the Hospital.

(e) use its best endeavours to ensure that patient care is delivered at the highest possible level of quality and efficiency and in accordance with these By-laws and subject to the available local resources;

(f) use its best endeavours to ensure that;

(i) education, teaching and research are fostered and promoted within the Hospital;

(ii) there is promoted within the Hospital a close working relationship between the Accredited Practitioners and the Hospital.

(g) assist in identifying health needs in the community and provide advice to the Hospital on appropriate services to meet those needs; and

(h) where appropriate and in association with the Ethics Committee, monitor progress of clinical research conducted or undertaken at the Hospital and in particular, its impact on clinical care, and make to the Board of Directors such recommendations as it considers appropriate;

(i) at the request of the Board of Directors provide advice on matters relating to clinical research or applications for clinical research conducted or undertaken at the Hospital;

(j) from time to time form and disband subcommittees to assist in their carrying out of functions. Such subcommittees shall consist of members of the Medical

Advisory Committee, Accredited Practitioners and may include, where appropriate, representation from Hospital administration, nursing service and other departments of the Hospital;

(k) be the formal body through which the views of the Accredited Practitioners of the Hospital shall be formulated and communicated;

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

(m) plan and manage a continuing education program for Accredited Practitioners or doctors in training where appropriate;

(n) advise the Board of Directors via the HEG of appropriate policies regarding the clinical organisation of the Hospital;

(o) if required by the Board of Directors, establish a mechanism for review of clinical outcomes and management and perform such a function in accordance with the requirements of these By-Laws;

(p) consider applications for appointment and re-appointment to the Accredited Practitioners of the Hospital and give due consideration to the training, experience, competence, judgement, professional capabilities and knowledge, Current Fitness, character and confidence held in any applicant for Accredited Practitioner and make recommendations thereon to the Board of Directors;

(q) review the recommendations of the Clinical Privileges Advisory Committee (if established) for the delineation, kind and extent of Clinical Privileges that should be granted to the applicant for appointment or re-appointment as an Accredited Practitioner and make a recommendation thereon to the Board of Directors including, without limitation, with respect to those matters set out in By-Law 11;

(r) consider the delineation, kind and extent of Clinical Privileges that should be granted to the applicant for appointment or re-appointment as an Accredited Practitioner and make a recommendation thereon to the Board of Management including, without limitation, with respect to those matters set out in By-Law 11;

(s) review the recommendations of the Clinical Privileges Advisory Committee (if established) as to applications by an Accredited Practitioner for the amendment of his or her Clinical Privileges and following due consideration make a

recommendation thereon to the Board of Directors as to the amendments sought;

(t) review the recommendations of the Clinical Privileges Advisory Committee (if established) in respect of the amendment or revocation of the current Clinical Privileges of an Accredited Practitioner, where the Board of Directors has directed the Clinical Privileges Advisory Committee to examine and investigate such Clinical Privileges, and make a recommendation thereon to the Board of Directors;

(u) consider the amendment or revocation of the current Clinical Privileges of an Accredited Practitioner, where the Board of Directors has directed the Medical Advisory Committee to examine and investigate such Clinical Privileges, and make a recommendation thereon to the Board of Directors;

(v) review any professionally recognised new or amended treatment, use of technology or procedure and make a recommendation on the amendment of the Clinical Privileges of an Accredited Practitioner;

(w) ensure that clinical review, monitoring and assessment activities are appropriate to the Hospital;

(x) ensure the Hospital quality improvement activities satisfy applicable quality assurance statutory requirements;

(y) develop and maintain an adequate clinical review and quality improvement program;

(z) make recommendations to the HEG regarding ongoing overall management of clinical review and quality improvement at the Hospital;

(aa) upon referral from the HEG, review the results of the clinical indicator program and take the appropriate action in respect of these results;

(bb) upon referral from the HEG, review unplanned re-admissions and transfers in and out of the Hospital, in and out of special care units, adverse events and deaths; and

(cc) such role as the Board of Directors may require from time to time.

In an emergency the HEG may act without advice from the Medical Advisory Committee in circumstances where that advice would ordinarily be required. The Medical Advisory Committee must consider the issue at a subsequent meeting.

**20.3. Constitution of Medical Advisory Committee**

(a) A Medical Advisory Committee of a Hospital may comprise of one active staff member elected from each of the following Departments:

(i) Department of Anaesthetics;
(ii) Department of Dentistry;
(iii) Department of Obstetrics and Gynaecology;
(iv) Department of General Practice;
(v) Department of General Surgery;
(vi) Department of Specialist Surgery;
(vii) Department of Medicine;
(viii) Department of Orthopaedics;
(ix) Department of Pathology;
(x) Department of Radiology;
(xi) Department of Paediatrics;
(xii) Director of Medical Services;
(xiii) Staff Medical Officer; and
(xiv) Other departments or speciality groups as required.

(b) The Board of Directors may disallow the nomination of an Accredited Practitioner nominated under By-Law 20.4 on the basis that the composition of the Medical Advisory Committee is, or will be, insufficiently representative of the range of work undertaken by the Accredited Practitioners at the Hospital.

(c) In addition to the Accredited Practitioner members appointed pursuant to By-Law 20.4, the Medical Advisory Committee shall comprise of the following ex officios:

(i) the Chief Executive Officer;
(ii) the Director of Clinical Services; and
(iii) any other person appointed by the Board of Directors from time-to- time.

**20.4. Election of Members of Medical Advisory Committee:**

(a) Elections for the Medical Advisory Committee will take place prior to, or at the Annual General Meeting of the Medical Association.

(b) The election of members of the Committee by each Department shall be conducted by ballot using the preferential system of voting.

(c) Each Accredited Practitioner who is a member of that Department may vote.

(d) The candidate with the greatest number of votes according to the preferential system shall be elected and if two candidates share an equal number of votes, the Representative of the Department or Chairperson may determine which of the two candidates has been elected.

(e) The following procedure shall be followed in conducting a ballot for the Medical Advisory Committee:

(i) Notices calling for nominations (with written acceptance of the nomination) to the Medical Advisory Committee shall be issued to all staff members by the HEG seven weeks prior to the Annual General Meeting.
(ii) Nomination to the Medical Advisory Committee shall be lodged with the HEG no later than four weeks prior to the Annual General Meeting.
(iii) Notices for the Annual General Meeting and ballot papers for election of Medical Advisory Committee members shall be issued by the HEG no later than three weeks prior to the Annual General Meeting.
(iv) Ballot papers for election to the Medical Advisory Committee shall be lodged with the HEG no later than three days prior to the Annual General Meeting.
(v) Votes recorded by ballot shall be counted at the Annual General Meeting.

(f) The accidental omission to forward a Medical Advisory Committee ballot paper to, or the non-receipt of a Medical Advisory Committee ballot paper by an Accredited Practitioner shall not invalidate the proceedings of an Annual General Meeting.

**20.5. Terms of Office:**

(a) Subject to this section, at each of the first three Annual General Meetings after these By-laws come into force, the number of Medical Advisory Committee members nearest to but not exceeding one third of the number of Medical Advisory Committee members shall retire from office.

(b) The order of retirement of these initial Medical Advisory Committee members shall be determined by agreement by those Medical Advisory Committee members and in default of agreement by lot.

(c) A Medical Advisory Committee member retiring pursuant to By-Law 20.5(a) shall hold office until the conclusion of the Annual General meeting at which the member retires but shall be eligible for re-election.

(d) The ex-officio members of the Medical Advisory Committee shall not be taken into account for the purpose of determining the number of members due to retire pursuant with By-Law 20.5(a).

(e) Subject to the above provisions, each Medical Advisory Committee member shall hold office until the conclusion of the third Annual General Meeting after the member's election but shall be eligible for re-election at the Annual General Meeting.

**20.6. Resignation or Removal of Medical Advisory Committee member:**

(a) A Medical Advisory Committee member may resign at any time by tendering a resignation in writing to the Committee. The resignation shall become effective upon acceptance by the Medical Advisory Committee.

(b) Regular attendance by members of the Medical Advisory Committee is highly desirable, therefore members who fail to attend meetings on three consecutive occasions without just cause shall be replaced on the Medical Advisory Committee.

(c) In the event of a replacement being required, the Chairperson of the Medical Advisory Committee shall be empowered to request the Director of Clinical Services to conduct a ballot to fill the vacancy from within the same Department as the resigning or replaced member.

**20.7. Replacement of vacancy of Medical Advisory Committee:**

(a) Any vacancy on the Medical Advisory Committee created by resignation or removal of a Medical Advisory Committee member may be filled by resolution of the Medical Advisory Committee and any person appointed pursuant to such resolution shall hold office until such time when the Medical Advisory Committee member who was replaced would have retired but shall be eligible for re-election.

(b) In filling a vacancy the Medical Advisory Committee shall appoint a person who is a member of the same Department as that to which the Medical Advisory Committee member whose place is to be filled belonged and such person shall for the purposes of these By-laws be deemed to have been elected by that Department.

**20.8. Meetings of the Committee:**

(a) The Medical Advisory Committee will hold a minimum of six (6) business meetings per annum.

(b) A quorum for a meeting of the Medical Advisory Committee will be per Clause 2.2(c).

(c) The HEG shall, upon request of the Chairperson of the Medical Advisory Committee or any three Medical Advisory Committee members, convene a meeting of the Medical Advisory Committee.

(d) Meeting dates will be set at the beginning of each year.

(e) Each voting Medical Advisory Committee member shall be entitled to one vote at meetings of the Medical Advisory Committee. In the case of an equality of votes, the Chairperson of the Medical Advisory shall have a second or casting vote.

(f) Attendance by teleconference will be considered when a Medical Advisory Committee is unable to attend a meeting in person with prior notification and approval from the Director of Clinical Services and/or the Director of Medical Services.

**20.9. Officers:**

(a) The officers of the Medical Advisory Committee shall be:

(i) Chairperson
(ii) Deputy Chairperson
(iii) Secretary/Treasurer (Director of Clinical Services)

(b) A Board appointed Director of Medical Services will assume the role of Chairperson of the Medical Advisory Committee. The Deputy Chairperson position is undertaken on a twelve month rotational basis sequentially by Department (refer 20.3(a)).

(c) Should the DMS position not be filled, at the first meeting of the Medical Advisory Committee after these By-laws come into force and thereafter at the first meeting of the Committee held after each Annual General Meeting, the Medical Advisory Committee members shall confirm one of their members be appointed Chairperson and Deputy Chairperson.

(d) The Chairperson of the Medical Advisory Committee shall be entitled to take the chair at all meetings of the Medical Advisory Committee. If at any such

meeting the Chairperson of the Medical Advisory Committee shall not be present, the Deputy Chairperson of the Medical Advisory Committee shall act as Chairperson of the Medical Advisory Committee for the purposes of that meeting. If neither the Chairperson of the Medical Advisory Committee or the Deputy Chairperson of the Medical Advisory Committee are present at any such meeting, then the Medical Advisory Committee members present shall elect one of their number to be Chairperson of the meeting.

**20.10. Duties of Officers:**

(a) The Chairperson of the Medical Advisory Committee will:

(i) Represent the Medical Advisory Committee in deliberations with the Board of Directors by invitation of request.
(ii) Encourage high standards of medical care.
(iii) Give guidance on overall medical policies to the Hospital.

(b) The Chairperson of the Medical Advisory Committee, Deputy Chairperson or delegate of the Medical Advisory Committee shall have the right to attend meetings of the Governing Body to raise issues of concern of the Medical Advisory Committee and participate in relevant discussions.

(c) The Chairperson of the Medical Advisory Committee should also call, preside at, and be responsible for the Agenda of all meetings.

(d) The Deputy Chairperson of the Medical Advisory Committee shall, in the temporary absence of the Chairperson of the Medical Advisory Committee, assume all duties and have authority of the Chairperson of the Medical Advisory Committee. The Deputy Chairperson of the Medical Advisory Committee shall also perform additional duties as may be assigned to that person by the Chairperson of the Medical Advisory Committee or Board of Directors.

(e) The Secretary/Treasurer shall be an ex-officio member of the Medical Advisory Committee and be responsible to give proper notice of all staff meetings and maintenance of accurate and complete minutes of all meetings. In addition, the Secretary/Treasurer will be responsible for other duties as may be assigned to that person by the Chairperson of the Medical Advisory Committee.

## 20.11. Terms of Reference

The Chief Executive Officer shall, where required specify in writing the terms of reference of the Medical Advisory Committee in addition to those set out in these By-Laws.

## 20.12. Confidentiality

The proceedings of the Medical Advisory Committee, its sub-committees and minutes of meetings thereof shall be kept strictly confidential to the Hospital.

## 20.13. Procedure of Medical Advisory Committee

(a) Entitlement to vote
Each member of the Medical Advisory Committee with the exception of the Chief Executive Officer and Director of Clinical Services and the nominees of Hospital management appointed by the Board shall have voting rights.

(b) Quorum
A constituted quorum will be per Clause 2.2 (c).

(c) Voting
All questions, excepting as otherwise provided in these By-Laws, shall be decided by a show of hands, or where demanded by a member entitled to vote, a ballot and the chairperson of the Medical Advisory Committee shall have a casting vote.

(d) Minutes

(i) Minutes of all meetings of the Medical Advisory Committee shall be recorded by a HEG appointed secretary.

(ii) Minutes shall be completed within 14 days of each meeting, circulated to the members for review and finalised within 4 weeks of the individual meetings.

(iii) Minutes shall be distributed by the HEG appointed secretary to all those entitled to attend meetings of the Medical Advisory Committee at least 7 days prior to the next meeting.

(iv) No business shall be considered at a meeting of the Medical Advisory Committee until the minutes of the previous meeting have been confirmed

or otherwise disposed of. No discussion of the minutes shall be permitted except as to their accuracy.

(v) Minutes of a meeting shall be confirmed by resolution and signed by the Chairperson of the Medical Advisory Committee at the next meeting and minutes so confirmed and signed shall be taken as evidence of proceedings thereat.

(vi) Minutes of a meeting of the Medical Advisory Committee will be forwarded to the Private Hospital Committee for consideration.

(vii) A permanent file of the minutes of each meeting shall be maintained.

**20.14. Representing the Hospital**

(a) No office bearer of a Medical Advisory Committee nor any of its members or subcommittees shall represent in any way that they represent the Hospital in any circumstances except with the express written permission of the HEG.

(b) Hospital letterhead shall only be used for official purposes and not for any other purposes.

(c) The Medical Advisory Committee shall have no power to enter into any contract or arrangement on behalf of, or otherwise to bind the Hospital.

## 21. CONFLICTS OF INTEREST

**21.1. Requirements for committee members**

(a) A member of any committee established under these By-Laws or a person authorised to attend any committee meeting who has a direct or indirect pecuniary interest or an actual conflict of interest or a potential conflict of interest;

(i) in a matter that has been considered or is about to be considered at a meeting; then

(ii) such a member or person shall not participate in the relevant discussion or resolution of any such interest or matter nor shall such a person be eligible to hold any office whilst such conflict of interest or potential conflict of interest exists; or in a thing being done or about to be done by the Hospital,

(iii) shall as soon as possible after the relevant facts have come to the person's knowledge, disclose the nature of the interest at the meeting.

The Chairperson of the Committee can make a determination in relation to the disclosure of an actual or potential conflict of interest. Specifically the Chairperson

may determine that the member must not participate in the meeting when the matter is being considered or that the member must not be present while the matter is being considered at the meeting or that the member may participate fully in the meeting when the matter is being considered.

(b) 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, 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,

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

(c) The Committee shall cause particulars of any disclosure made under By-Laws 21.1(b) to be recorded in the minutes of the relevant meeting and declared by the member or authorised person in writing on a pecuniary interest/conflict of interest declaration form.

(d) A Committee Member must make himself or herself aware of the requirements of the Trade Practices Act in relation to Anti-Competitive Conduct.

(e) If a Chair of a Committee becomes aware that a Committee Member has failed to report a Conflict of Interest will report the matter to the HEG. Consideration as to any disciplinary action required will be considered pursuant to these By-Laws.

(f) Mildura District Hospital Fund, in respect of any person who is appointed in accordance with these By-Laws to be a member of the Medical Advisory Committee (or any sub-committee of such a committee) will indemnify the person in respect of any liability the person incurs in respects of acts done or omissions or statements made by the person in good faith in the course of performing the functions of a relevant committee member.

## 22. TREATMENT OF FAMILY MEMBERS

Accredited Practitioners may not treat a member of their immediate family at the Hospital.

**ANNEXURE**

**CRITERIA FOR EACH ACCREDITATION CATEGORY**

**Subject to By-Laws (refer to categories of Accredited Practitioners in By-Law 8)**

| **Category of Appointment** | **Details** |
|---|---|
| Accredited Practitioner (Admitting rights)<br>*Note: Interventional Radiologists have admitting rights for day patient procedures and, for overnight patients, for post procedure observation only.* | • Registration by AHPRA under the *Health Practitioner Regulation National Law (Victoria) Act 2009*.<br>• Appropriate professional indemnity insurance coverage or equivalent membership of a medical defence organisation.<br>• Specialist with an Australian Fellowship or equivalent; recognised under the *Health Insurance Act 1973* (Comth) as a specialist.<br>• May admit and treat patients within the terms of their Clinical Privileges.<br>• Responsible for the clinical care of their inpatients.<br>• Participates in continuing education activities of the Hospital.<br>• Demonstrates a commitment to the Hospital e.g. teaching research or does not obstruct legitimate research at the Hospital.<br>• Participates in clinical audit activities at the Hospital. |
| Staff Specialist | • Registration under *Health Practitioner Regulation National Law (Victoria) Act 2009.*<br>• Appropriate professional indemnity insurance coverage or equivalent membership of a medical defence organisation. |

| | |
|---|---|
| | • Specialist with an Australian Fellowship or equivalent; recognised under the *Health Insurance Act 1973* (Cth) as a specialist.<br>• May admit and treat patients within the terms of their Clinical Privileges.<br>• Responsible for the clinical care of their inpatients.<br>• Participates in continuing education activities of the Hospital.<br>• Demonstrates a commitment to the Hospital e.g. teaching research or does not obstruct legitimate research at the Hospital.<br>• Participates in clinical audit activities at the Hospital. |
| Career Medical Officer | • Registration by AHPRA under *Health Practitioner Regulation National Law (Victoria) Act 2009.*<br>• May treat patients under the supervision of a Visiting Medical Officer or Staff Specialist.<br>• Participates in continuing education activities of the Hospital. |

**ANNEXURE B**

**RULE AND REGULATIONS**

1. A patient may be admitted to the Hospital only by an Accredited Medical Practitioner who has successfully met the credentialing process and been accepted by the Board of Directors to admit patients. All practitioners shall be governed by the official admitting policies of the Hospital.

2. The Hospital shall accept patients for care and treatment according to the criteria laid down from time to time by the Board of Directors after consultation with the Medical Advisory Committee.

3. An Accredited Medical Practitioner shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the patient's medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring doctor and to relatives of the patient. Whenever these responsibilities are transferred to another Accredited Medical Practitioner, a statement covering the transfer of responsibility shall be entered in the medical record.

4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

5. Patients admitted for surgical procedures must have all admission requirements completed including operative and anaesthetic consents.

6. For non-booked admissions the Accredited Medical Practitioner shall, when possible, first contact Director of Clinical Services or the Afterhours Clinical Coordinator to ascertain bed availability.

7. Each Accredited Medical Practitioner, when caring for patients, will name another Accredited Medical Practitioner to deputise on their behalf for inpatient, postoperative and emergency call care when absent / away and until that practitioner returns.

8. The admitting Accredited Medical Practitioner shall give all information to the Hospital as may be necessary to assure the protection of the patient from self-harm and to assure the protection of other patients.

9. Patients shall be discharged only on the order of the attending Accredited Medical Practitioner or deputy as in 7. above. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the

incident shall be made in the patient's medical record and the patient asked to sign the notation. In the event that the patient refuses to sign the notation the staff member making the notation should record that fact on the medical record.

10. In the event of a patient's death, certification by the attending Accredited Medical Practitioner or deputy as in 7. should occur as soon as possible, unless it is a matter to be reported to the Coroner. Policies with respect to release of the body shall conform to local and State law.

11. The attending Accredited Medical Practitioner shall be responsible for the preparation of a legible original medical record for each patient, its contents to be pertinent and shall include all relevant data. All forms shall be completed within twenty-four (24) hours of the patient's admission.

12. When an appropriate history and physical examination and treatment plan are not recorded before an operation or any diagnostic procedure, the procedure shall be delayed while the situation is corrected unless the attending Accredited Medical Practitioner states in writing that such delay would be detrimental to the life and recovery to the health of the patient. Post-operative/procedural completion of the medical record is mandatory in these cases.

13. Pertinent progress notes shall be recorded at the time of each observation/visit sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the medical file and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on those where there is difficulty in diagnosis or management of the clinical problem.

14. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be written (or dictated) immediately following surgery when possible, but always within twenty-four (24) hours post surgery and the report promptly signed by the Surgeon and made a part of the patient's medical record. Where an operative report is completed in the Surgeons' rooms a copy shall be forwarded to the hospital for inclusion in the patients' medical record.

15. Consultations shall show evidence of a review of the patient's record by the Accredited Practitioner, the Accredited Practitioner's opinion and recommendations. When operative procedures are involved, the consultation note shall, except in emergency situations, be verified on the record and be recorded prior to the operation.

16. Where major surgery is performed by a visiting surgeon requiring the patient to be hospitalised for overnight or several days and the surgeon is required to leave the

district, this must not be before a period of 24 hours has elapsed from the completion of surgery. The patient must be in a stable condition to transfer care to the nominated Accredited Practitioner after that 24 hour period has passed. Day surgery procedures are exempt from this regulation unless overnight observation is required. Should a day surgery patient remain an inpatient for reasons other than the surgical procedure a written transfer of care to a nominated Accredited Medical Practitioner can be exercised.

17. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated.

18. Final diagnosis shall be recorded in full.

19. A discharge summary or letter shall be written in all medical files of the hospitalised patient.

20. Written consent of the patient is required for release of medical information to unauthorised persons.

21. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Director of Clinical Services. In any case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorised removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Advisory Committee.

22. A medical record shall not be permanently filed until it is completed by the responsible practitioner.

23. An Accredited Medical Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner.

24. An informed consent for treatment form when applicable, signed by or (appropriately) on behalf of every patient admitted to the Hospital, must be obtained before admission and forwarded to the Hospital by the attending practitioner whenever such consent has not been previously obtained. Except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient receives any treatment in the Hospital.

25. All orders for treatment shall be in writing by the attending Accredited Medical Practitioner. A verbal order shall be considered to be in writing if dictated to a duly

authorised person functioning within their scope of practice. Signing by the responsible Accredited Medical Practitioner should take place at the next visit within 24 hours.

26. Exceptions to this procedure may occur in times of emergency, in which case the order shall be signed by the appropriately authorised person to whom dictated, with the name of the practitioner per his/her own name. The responsible Accredited Medical Practitioner shall authenticate such orders at the next visit, within twenty-four (24) hours, and repeated failure to do so shall be brought to the attention of the HEG who may advise the Medical Advisory Committee for appropriate action.

27. The Accredited Medical Practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.
Each patient must have a completed medication chart covering all medications to be administered taking into account medications taken prior to admission.

28. There shall be an automatic "stop order" after seven days of drug administration unless the duration of the order is specifically designated. Every effort shall be made by the nursing staff to notify the Accredited Medical Practitioner before exercising the automatic "stop order".

29. The attending Accredited Medical Practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. The attending practitioner will provide written authorisation to permit another attending practitioner to attend or examine his/her patient, except in an emergency.

30. Consultation request forms for radiology and pathology shall be fully completed and signed by the attending Accredited Medical Practitioner. The attending practitioner is responsible for providing all necessary clinical data.

31. In the case of a patient scheduled for an operative procedure, relevant history, examination, investigation reports, appropriate consents, and consultations when requested, shall be recorded. In the case of an extreme emergency when the operating surgeon is willing to state that a delay in obtaining the above would be detrimental to the life and well-being of a patient, the Operating Room Nurse Unit Manager or deputy will accept the patient for surgery. However, a report of the incident shall be made to the Director of Clinical Services and the Chairperson of the Medical Advisory Committee as soon as possible.

32. Written, signed, informed, surgical consent shall be obtained by the attending Accredited Medical Practitioner prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor, an unconscious patient or any other patient for which consent for surgery cannot be

immediately obtained from the patient's parents, a guardian, next of kin, or other appropriate personal representative, these circumstances should be fully recorded in the patient's medical record.

33. Where possible, the signature of two registered Accredited Medical Practitioners should be obtained on the consent attesting to the fact that in both their opinions the situation at hand is considered an emergency. An emergency exists when the patient is in immediate danger of permanent injury or loss of life and any delay in the judgment of the attending practitioner in administering treatment would increase the danger.

34. The Anaesthetist shall maintain a complete anaesthesia record to include evidence of pre-anesthetic evaluation and post anaesthetic instruction and/or follow-up of the patient's condition.

35. All specimens removed at the operation shall be sent to a Pathologist who shall make examination as may be necessary to arrive at a tissue diagnosis. This authenticated report shall be made part of the patient's record.

36. Records necessary for these procedures will include pertinent history, physical findings, diagnosis and description of procedure. These records are the responsibility of the operating surgeon and should be completed on completion of the procedure.

37. All X-Ray and Pathology reports are to be included in the patient's medical record within twenty-four (24) hours after being received and reviewed.

38. If a decision has been made by the attending Accredited Medical Practitioner after due consultation and discussion with all relevant parties that no active resuscitation methods are to be instigated, then this information must be written in the patient's medical history on this and each subsequent admission.

39. Medical assistants or other personnel not employed or appointed by the Hospital but required or requested by an Accredited Medical Practitioner to assist them, must be reviewed and approved by the HEG. As a minimum, proof of AHPRA registration and Medical Indemnity Insurance must be provided.

**ANNEXURE C**

## ACCREDITATION GUIDELINES