MACQUARIE UNIVERSITY HOSPITAL BY-LAWS

Approved by order of the board of MUH Operations No. 2 Pty Limited, with effect from 27 February 2018

Contents

Macquarie University Hospital By-laws

Part A Introduction

1. By-law Objects

The objects of these By-laws are to:

(a) ensure that only Health Service Providers who are suitably trained and qualified to practise in a competent and ethical manner and who continue to demonstrate the highest levels of professional behaviour in all aspects of their practice are Accredited;

(b) facilitate the provision of health services at the Hospital which are safe, of an appropriate quality to give patients a positive experience of their care in an environment where the wellbeing and the interests of patients is paramount;

(c) facilitate high quality and ethical medical and other research at the Hospital and University;

(d) facilitate the provision of high quality education and training of students at the Hospital and University; and

(e) enable the continuous development of a flexible, responsive and sustainable health workforce at the Hospital and to enable innovation in the education of Health Service Providers and in the provision of health services, at the Hospital.

2. Dictionary of defined terms.[1]

Expressions used in these By-laws that are defined in the dictionary at the end of these By-laws have the meanings set out in the dictionary.

Part B Accreditation

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

3.1 Admission of patients

3.1.1. A Medical Practitioner is only permitted to admit a patient to the Hospital if:

(a) the Medical Practitioner is Accredited; and

(b) their Scope of Clinical Practice includes the admission of patients to the Hospital.

3.1.2. Subject to By-laws 3.1.3 and 3.1.4, Hospital Medical Officers and Dentists are not permitted to admit patients to the Hospital.

[1] The dictionary defines certain terms used in these By-laws.
A definition in the dictionary applies to all of these By-laws including its schedules unless a contrary intention appears.
Terms defined in the dictionary are identified in these By-laws by having an upper case first letter.

3.1.3. A Hospital Medical Officer may admit patients if treatment will subsequently be undertaken by an Accredited Medical Practitioner whose Scope of Clinical Practice includes the admission of patients for the required treatment.

3.1.4.

(a) A Dentist, is not permitted to admit patients to the Hospital unless the Chief Executive Officer has authorised him or her to do so.

(b) The Chief Executive Officer may authorise a Dentist to admit patients to the Hospital subject to any conditions that the Chief Executive Officer considers appropriate.

3.2 Treatment of Patients

A Health Service Provider is only permitted to provide health services to a patient at the Hospital if he or she is Accredited and in the case of an Accredited Medical Practitioner may only provide health services to patients at the Hospital within his or her Scope of Clinical Practice and in accordance with their type of registration under the National Regulation Law.

3.3 Limitation

(a) Accreditation does not give an Accredited Person:

(i) any right to access the Hospital or any facility in the Hospital;

(ii) any right to any operating session or list at the Hospital or to participate in any session or list;

(iii) any right to admit patients to the Hospital;

(iv) any right to have beds allocated for patients admitted by him or her to the Hospital; or

(v) any right to referral of patients from any person.

(b) An Accredited Person has no right to Accreditation after the termination or expiry of their period of Accreditation.

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4. Granting Accreditation

4.1 Categories

4.1.1. Accreditation may be granted to a Health Service Provider in any of the following categories:

(a) Medical Practitioner;

(b) Dentist;

(c) Allied Health Practitioner;

(d) Nurse; or

(e) Health Care Worker.

4.2 Approval of Accreditation Standards

4.2.1. The Board may, at any time, require the Medical Advisory Committee to:

(a) propose and recommend Accreditation Standards; or

(b) review an approved or proposed Accreditation Standard.

4.2.2. The Board may approve an Accreditation Standard applicable to Accreditation.

4.2.3. The Board may approve an Accreditation Standard for a health profession only after having proper regard to any recommendations of the Medical Advisory Committee.

4.2.4. Accreditation may only be granted after having proper regard to any applicable Accreditation Standard and any recommendations of the Medical Advisory Committee.

4.3 Term of Accreditation

4.3.1.

(a) Subject to this By-law 4.3.1, the period of Accreditation of a Medical Practitioner who has specialist or general registration under the National Regulation Law is for a period determined by the Board not exceeding five (5) years;

(b) The period of Accreditation of an Accredited Medical Practitioner who:

(i) provides health services at the Hospital on behalf of a contracted service provider (including a diagnostic imaging or pathology services provider), is for the duration of the contract under which the contracted service provider is engaged by the Hospital Licensee;

(ii) provides health services at the Hospital as an employee or contractor of the Hospital Licensee or MUCA, is for the duration of the contract under which the Health Services Provider is employed or engaged by MUCA or the Hospital Licensee, as the case requires; or

(iii) is undertaking training or a program of study at the Hospital (including for the purpose of qualifying as a fellow or equivalent of a specialist medical college), is for the duration of their period of training or study.

4.3.2.

(a) The Chief Executive Officer may terminate the Accreditation of an Allied Health Practitioner, Nurse or Health Care Worker at any time by giving written notice to that effect to that Accredited Person.

(b) Termination will take effect when the Accredited Person is given the termination notice or at a later date specified in that notice.

(c) An Allied Health Practitioner, Nurse or Health Care Worker has no right of appeal against a decision made pursuant to this By-law 4.3.2.

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5. Applications for Accreditation

5.1 Application procedure

5.1.1.

(a) A Health Service Provider may apply for Accreditation by providing the Chief Executive Officer with a written application in the form required by the Chief Executive Officer.

(b) If an application is made online in a manner approved by the Chief Executive Officer, then it will be taken to be a written application for the purposes of this By-law 5.

5.1.2. The Chief Executive Officer:

(a) must refer an application by a Medical Practitioner; and

(b) may refer an application for Accreditation by an Allied Health Practitioner, Nurse or Health Care Workers,

to the Medical Advisory Committee for its review and recommendation.

5.1.3. If an application for Accreditation is referred to the Medical Advisory Committee pursuant to By-law 5.1.2, it must after considering the application for Accreditation recommend to the Chief Executive Officer:

(a) whether or not the Accreditation Applicant should be granted Accreditation; and

(b) any Special Conditions which should apply to the Accreditation Applicant.

5.2 **Application for Accreditation - General**

5.2.1. An Accreditation Applicant by making an application represents to the Hospital Licensee that:

(a) he or she has the Required Insurance and it is binding on the insurer, is not voidable by the insurer and can be enforced against the insurer in accordance with its terms;

(b) all information given to and each statement made to the Hospital Licensee by or at the direction of the Accreditation Applicant in relation to the application is true, complete and not misleading; and

(c) the Accreditation Applicant has otherwise disclosed to the Hospital Licensee all information known to the Accreditation Applicant which a reasonable person would consider relevant to the assessment by the Hospital Licensee of the Accreditation Applicant's suitability for Accreditation.

5.2.2. An Accreditation Applicant must:

(a) pay any fee and provide, documentation and information required by the Hospital Licensee in relation to the Accreditation application;

(b) authorise the Hospital Licensee to obtain information relevant to the Accreditation Applicant's application for Accreditation from third parties (including the registration authorities, referees and operators of Health Facilities at which the Accreditation Applicant currently or has previously worked);

(c) authorise the Hospital Licensee to undertake any inquiry for the purposes of the *Child Protection (Working with Children) Act 2012* (NSW), or other legislation with similar objectives, where required by law or Hospital Regulations;

(d) authorise the Hospital Licensee to undertake any inquiry for the purposes of ascertaining the Criminal History (if any) of the Accreditation Applicant;

(e) authorise the Hospital Licensee to co-operate with the operator of any other Health Facility in relation to any investigation, enquiry or process relevant to the Accreditation Applicant's suitability to practice at the Hospital or any other Health Facility;

(f) inform the Hospital Licensee if they have previously been refused accreditation to provide health services at any other Health Facility or if otherwise permission to provide health services at any other Health Facility has been refused or withdrawn or given subject to conditions;

(g) provide details of any notifications made to their professional indemnity insurer in the past 5 years; and

(h) provide evidence of any immunisations and health status required by the Hospital Licensee.

5.2.3. An Accreditation Applicant by making an application, agrees to comply with all Hospital Regulations.

5.2.4.

(a) The Hospital Licensee may, at any time before or after an application for Accreditation is made, request the Accreditation Applicant to provide evidence of the Accreditation Applicant's identity.

(b) The Accreditation Applicant must not, without reasonable excuse, fail to promptly comply with the request.

(c) If an Accreditation Applicant gives the Hospital Licensee a document as evidence of their identity pursuant to this By-law 5.2.4, the Chief Executive Officer may, by written notice, request the entity that issued the document to:

(i) authenticate the document; and

(ii) give the Hospital Licensee any other information relevant to the Accreditation Applicant's identity.

(d) An Accreditation Applicant must promptly authorise a person given a notice under this By-law 5.2.4 to provide anything requested.

5.2.5.

(a) The Chief Executive Officer must consider an application for Accreditation having regard to the:

(i) the business plans of the Hospital Licensee;

(ii) the Objects; and

(iii) the outcome of any consultation with the executive dean of the Faculty;

and may undertake any other enquiry or consultation relating to consideration of the application that he or she thinks appropriate.

(b) The Chief Executive Officer must then determine whether the application is to be given further consideration pursuant to By-laws 5.2.5 and 5.2.6.

(c) If the Chief Executive Officer decides that the application will not be given further consideration, the Chief Executive Officer is not required to give reasons for that decision to the Accreditation Applicant.

5.2.6. If the Chief Executive Officer decides that the application for Accreditation is to be given further consideration:

(a) the Chief Executive Officer may require the Accreditation Applicant to attend an interview;

(b) the Chief Executive Officer may consult one or more referees nominated by the Accreditation Applicant;

(c) the Chief Executive Officer may consult with and obtain information from any other Health Facility at which the Accreditation Applicant has previously provided health services;

(d) the Chief Executive Officer must, in the case of an application by a Medical Practitioner:

(i) consult with the Clinical Program Head about the Scope of Clinical Practice relevant to the Accreditation Applicant; and

(ii) refer the Accreditation Applicant's application for Accreditation and any information the Chief Executive Officer considers relevant, to the Medical Advisory Committee for its review and recommendations.

5.2.7. The Medical Advisory Committee, Chief Executive Officer or Board, as the case requires, must in assessing any application for Accreditation, have regard to:

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

(b) in the case of an application by a Medical Practitioner, the Scope of Clinical Practice sought;

(c) any Special Conditions which should apply to the Accreditations sought;

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

(e) the Accreditation Applicant's character and good standing with his or her peers;

(f) the Hospital Licensee's ability to provide the facilities and health services and other support services which are relevant to the Accreditation sought and, in the case of an application by a Medical Practitioner, the Scope of Clinical Practice sought;

(g) any guidelines of the Hospital Licensee relating to Credentialing and, in the case of an application by a Medical Practitioner, determining the Scope of Clinical Practice applicable;

(h) if the Accreditation Applicant has disclosed an Impairment, the Accreditation Applicant's physical and mental health;

(i) where the Accreditation Applicant is currently, or has previously been, an Accredited Person, the Accreditation Applicant's demonstrated clinical performance, participation in clinical review and quality assurance activities and cooperation with the Hospital Licensee's officers and staff and with other Accredited Persons;

(j) in the case of the Board or the Chief Executive Officer, any recommendations of the Medical Advisory Committee;

(k) any other criteria the assessor considers relevant in the circumstances; and

(l) whether the Accreditation Applicant is otherwise a fit and proper person for Accreditation.

5.2.8. The Board must decide:

(a) whether an Accreditation Applicant who is a Medical Practitioner should be granted the Accreditation applied for;

(b) the Scope of Clinical Practice for which the Accreditation Applicant should be Accredited; and

(c) any Special Conditions which should apply.

5.2.9. The Chief Executive Officer must decide:

(a) whether an Accreditation Applicant who is an Allied Health Practitioner, Nurse or Health Care Worker should be granted the Accreditation applied for; and

(b) any Special Conditions which should apply to the Accreditation.

5.2.10. If the Accreditation Applicant is granted Accreditation, the Chief Executive Officer must notify the Accreditation Applicant in writing within 20 Working Days setting out:

(a) the term of the Accreditation;

(b) in the case of an application by a Medical Practitioner, the Scope of Clinical Practice; and

(c) any Special Conditions which will apply to the Accreditation.

5.2.11. If the Board or the Chief Executive Officer, as the case requires, decides that an Accreditation Applicant is not to be granted Accreditation (or in the case of an application by a Medical Practitioner, that the Accreditation Applicant's Scope of Clinical Practice, be materially more limited than that sought), the Chief Executive Officer must promptly notify the Accreditation Applicant.

5.2.12. If the Chief Executive Officer decides that the application will not be given further consideration, the Chief Executive Officer is not required to give reasons for that decision to the Accreditation Applicant.

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6. Applications for Temporary Accreditation

6.1 Application

6.1.1. A Health Service Provider may apply for temporary Accreditation by providing to the Chief Executive Officer a written application in the form required by the Chief Executive Officer.

6.1.2. The Chief Executive Officer may grant temporary Accreditation for a period not exceeding 6 months if he or she is satisfied it is in the interests of the Hospital Licensee to do so and must determine any Special Conditions and, in the case of an application by a Medical Practitioner, the Scope of Clinical Practice applicable to the temporary Accreditation.

6.1.3. The Chief Executive Officer before granting or extending the period of temporary Accreditation, determining any Special Conditions and the Scope of Clinical Practice which will apply, must consult with the chair of the Medical Advisory Committee and the relevant Clinical Program Head.

6.2 Duration

6.2.1. Temporary Accreditation granted under this By-law 6 will terminate at the earlier of:

(a) if the temporarily Accredited Medical Practitioner has also applied for Accreditation for a term, when the Board determines that application; or

(b) the expiry of the period for which temporary Accreditation is granted.

6.2.2. The Chief Executive Officer may extend temporary Accreditation for one further period of no greater than 6 months.

6.3 Notice

6.3.1. If an applicant is granted temporary Accreditation or their temporary Accreditation is extended, the Chief Executive Officer must give a notice to the Accreditation Applicant, the Board, the Medical Advisory Committee and the relevant Clinical Program Head which sets out:

(a) the period of Accreditation;

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

(c) any Special Conditions which will apply to the Accreditation.

6.4 **Termination**

6.4.1. Temporary Accreditation given under this By-law 6 may be terminated by the Board or the Chief Executive Officer at any time.

6.4.2. Termination of temporary Accreditation will not be treated as termination of Accreditation for the purpose of By-law 6.

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7. Applications for Renewal of Accreditation

7.1 **Accreditation Renewal**

7.1.1. An Accredited Medical Practitioner may apply to the Chief Executive Officer for renewal of his or her Accreditation in accordance with this By-law 7.

7.1.2. An application for renewal of an Accredited Medical Practitioner's Accreditation must be made at least two months before the Accredited Medical Practitioner's period of Accreditation expires.

7.1.3. The application for renewal of Accreditation must:

(a) be accompanied by any fee required by the Board; and

(b) be accompanied by any information required by the Hospital Licensee.

7.1.4. The Chief Executive Officer in relation to any application for renewal of Accreditation, may waive any requirement for the Accreditation Applicant to provide any documentation or information if the Chief Executive Officer is satisfied that the provision of the documentation information if he or she considers it is unnecessary in the circumstances.

7.2 **Hospital Licensee's powers before making decision**

7.2.1. The Board may renew the Accreditation of an Accredited Medical Practitioner.

7.2.2. If the Board renews an Accreditation, the Accreditation is subject to:

(a) any condition to which the Accreditation was subject immediately before the renewal; and

(b) any other condition the Board considers necessary or desirable in the circumstances.

7.2.3. An Accreditation renewed under this By-law 7 begins when the Accreditation Applicant's previous period of Accreditation expires.

7.2.4. The provisions of By-law 6 will apply, with necessary adaptations, to any application for renewal of Accreditation.

7.3 **Lapsing of Accreditation**

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

7.3.2. The Chief Executive Officer may accept an application for renewal of Accreditation after the time for lodging an application for renewal of Accreditation has expired if he or she is satisfied that the affected Accredited Medical Practitioner, has a reasonable excuse for not lodging his or her application or request in accordance with these By-laws.

8. Voluntarily terminating Accreditation

8.1 Termination by Accredited Person

8.1.1. An Accredited Person may terminate his or her Accreditation by written notice to the Chief Executive Officer.

8.1.2. The Accreditation will end on the date the notice is received or a later date specified in the notice which is a date before the expiration of the term of that Accredited Medical Practitioner's Accreditation.

9. Transition on Termination of Accreditation

9.1 Co-operation – general

When the Accreditation of an Accredited Person ends (including by termination or expiration), the Accredited Person must comply with the reasonable requirements of the Hospital Licensee and otherwise co-operate with the Hospital Licensee with respect to the discharge of patients admitted to the Hospital or transfer of care of admitted patients to another Accredited Person.

9.2 Co-operation after accreditation ends

This By-law 9 survives the termination an Accredited Person's Accreditation.

10. Medical Observers

10.1 Chief Executive Officer's consent

A person may not be a Medical Observer at the Hospital without the Chief Executive Officer's prior consent.

10.2 Conditions

Any consent to be a Medical Observer may:

(a) be given subject to any conditions the Chief Executive Officer considers appropriate; and

(b) be amended or withdrawn if and when the Chief Executive Officer considers appropriate.

11. Amendment of Scope of Clinical Practice (on request by Accredited Medical Practitioner)

11.1 Application

11.1.1. An Accredited Medical Practitioner may, at any time, make an application to amend his or her Scope of Clinical Practice.

11.1.2. The Chief Executive Officer must provide any such application to the Medical Advisory Committee.

11.2 Procedure

The procedures for amendment of an Accredited Medical Practitioner's Scope of Clinical Practice will be the same (with necessary adaptations) as for an application for initial Accreditation under By-law 5, except that the Chief Executive Officer may (after consultation with the Medical Advisory Committee) waive or modify a generally applicable requirement to

provide documentation or information if he or she considers it is unnecessary to prove it in the circumstances.

11.3 **Notice**

11.3.1. The Chief Executive Officer must promptly notify the Accredited Medical Practitioner in writing of the Board's decision in relation to an application to amend a Scope of Clinical Practice.

11.3.2. The notice must set out the Accredited Medical Practitioner's amended Scope of Clinical Practice and any Special Conditions which will apply to the Accredited Medical Practitioner's amended Scope of Clinical Practice.

12. Review of Scope of Clinical Practice for Medical Practitioner

12.1 **Internal Review**

12.1.1. The Chief Executive Officer or the Board may, at any time, direct the Medical Advisory Committee to review an Accredited Medical Practitioner's Scope of Clinical Practice.

12.1.2. The Accredited Medical Practitioner must provide the Medical Advisory Committee with any documentation and information required by the Medical Advisory Committee (and must otherwise cooperate with the Medical Advisory Committee) for the purpose of reviewing the Accredited Medical Practitioner's Scope of Clinical Practice.

12.1.3. The Medical Advisory Committee:

(a) must review an Accredited Medical Practitioner's Scope of Clinical Practice if directed to do so by the Board or the Chief Executive Officer;

(b) at any time during the review, may make a recommendation to the Chief Executive Officer or the Board that the Accredited Medical Practitioner's Accreditation be suspended under By-law 14 pending completion of the review; and

(c) at completion of the review, must make a recommendation to the Board concerning any of the following:

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

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

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

12.1.4. The Board must make a decision in relation to the matter having regard to the recommendation of the Medical Advisory Committee.

12.1.5. The Chief Executive Officer must notify the Accredited Medical Practitioner in writing of the Board's decision in relation to the review initiated.

12.1.6. Where applicable, the notice must promptly set out the Accredited Medical Practitioner's amended Scope of Clinical Practice and any Special Conditions applicable to the Accredited Medical Practitioner's amended Scope of Clinical Practice.

12.2 **External (Independent) Review**

12.2.1. The Chief Executive Officer or the Board may, at any time, appoint an Independent Reviewer to review an Accredited Medical Practitioner's Scope of Clinical Practice.

12.2.2. A review may be initiated at any time that the Chief Executive Officer or the Board is satisfied is appropriate having regard to matters relating to the Accredited Medical Practitioner, the Hospital or the University.

12.2.3. The Chief Executive Officer must notify the chair of the Medical Advisory Committee of the appointment of an Independent Reviewer under By-law 12.2.1.

12.2.4. The Accredited Medical Practitioner must provide the Independent Reviewer with any documentation and information for the purpose of the review required by the Independent Reviewer (and must otherwise cooperate with the Independent Reviewer) to review the Accredited Medical Practitioner's Scope of Clinical Practice.

12.2.5. The Independent Reviewer:

(a) at any time during the review, may make a recommendation to the Chief Executive Officer or the Board that the Accredited Medical Practitioner's Accreditation be suspended under By-law 13 until completion of the review; and

(b) at completion of the review, must make a recommendation to the Board concerning any of the following:

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

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

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

12.2.6. The Chief Executive Officer must notify the chair of the Medical Advisory Committee of the recommendations of the Independent Reviewer under By-law 12.2.5.

12.2.7. The Board, following receipt any recommendations of an Independent Reviewer, must make a decision concerning any of the following:

(a) the continuation, suspension or termination of the Accredited Medical Practitioner's Accreditation;

(b) the amendment of the Accredited Medical Practitioner's Scope of Clinical Practice; or

(c) the imposition of any Special Conditions on the Accredited Medical Practitioner's Accreditation.

12.2.8. The Chief Executive Officer must notify the Accredited Medical Practitioner in writing of the Board's decision in relation to the review.

12.2.9. Where applicable, the notice must set out the Accredited Medical Practitioner's amended Scope of Clinical Practice and any Special Conditions which apply to the Accredited Medical Practitioner's amended Scope of Clinical Practice.

13. Suspension of Accreditation

13.1 Suspension Grounds

13.1.1. The Chief Executive Officer may suspend the Accreditation of any Accredited Person if the Chief Executive Officer:

(a) reasonably believes or suspects that a Suspension Event has occurred in respect of that Accredited Person;

(b) has received a complaint from any person to the effect that a Suspension Event has occurred and the Chief Executive Officer is satisfied that the complaint is not vexatious, frivolous or otherwise without substance; or

(c) has received a recommendation from the Medical Advisory Committee or an Independent Reviewer under By-law 12.2.5, that the Accreditation of an Accredited Medical Practitioner be suspended.

13.1.2. To form a reasonable belief or suspicion that a Suspension Event has occurred under clause 13.1.1 (a), the Chief Executive Officer must have obtained relevant information in existence at the time, including from the Accredited Person.

13.1.3. Suspension of an Accredited Person takes effect immediately upon the Chief Executive Officer notifying that Accredited Person of the decision to suspend the Accredited Person.

13.2 **Conditions**

The Chief Executive Officer may decide that a suspension will continue until particular conditions determined by the Chief Executive Officer are satisfied.

13.3 **Termination of suspension and reinstatement**

13.3.1. The Chief Executive Officer may, at any time:

(a) reinstate any Accreditation suspended under this By-law 13; or

(b) impose, amend or remove conditions which must be satisfied before Accreditation is reinstated.

13.3.2. The suspension of Accreditation ends:

(a) on termination Accreditation under By-law 14; or

(b) on receipt by the Accredited Person of notice from the Chief Executive Officer that Accreditation has been reinstated.

13.3.3. The reinstatement of Accreditation may be unconditional or subject to any Special Conditions determined by the Chief Executive Officer and specified in the notice of reinstatement.

13.4 **Notice of suspension (Accredited Persons)**

13.4.1. The Chief Executive Officer must promptly notify the Accredited Person and the Board of:

(a) the decision to suspend the Accreditation of the Accredited Person; and

(b) if the suspension is expressed to continue until a particular event or circumstance occurs or arises, the relevant event or circumstance.

13.5 **Consultation required**

The Chief Executive Officer must, if he or she is satisfied that it is practicable in the circumstances to do so, consult with the chair of the Medical Advisory Committee before exercising any power to:

(a) suspend an Accredited Person;

(b) reinstate the Accreditation of an Accredited Person; or

(c) impose, amend or remove conditions which must be satisfied before the suspended of Accreditation is reinstated.

14. Termination of Accreditation

14.1 Termination grounds

The Board may terminate an Accredited Person's Accreditation if it is satisfied that a Termination Event has occurred in respect of that Accredited Person.

14.2 Notice of termination

The Chief Executive Officer must promptly notify the Accredited Person of the decision to terminate his or her Accreditation.

15. Health Care Worker – Code of Conduct and Hospital Requirements

All Health Care Workers must comply with the Code of Conduct for unregistered health practitioners made under the Public Health Regulation 2012 (NSW).

In these By-laws, the following conduct of a Health Care Worker is regarded as unacceptable:

(a) conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the Health Care Worker in the practice of the Health Care Worker's profession is significantly below the standard reasonably expected of a Health Care Worker of an equivalent level of training or experience;

(b) a contravention by the Health Care Worker (whether by act or omission) of a provision of any statute, delegated legislation, code of conduct or disciplinary procedure regulating or dealing with the Health Care Worker's profession, whether or not the Health Care Worker has been charged with or had a criminal finding for an offence in respect of the contravention or had an adverse disciplinary finding in respect of the contravention;

(c) a contravention by the Health Care Worker (whether by act or omission) of a decision or order made by a regulatory, professional or disciplinary body governing or overseeing the Health Care Worker's performance or disciplinary matters in relation to the Health Care Worker's profession;

(d) a contravention by the Health Care Worker of section 34A(4) of the *Health Care Complaints Act 1993* (NSW);

(e) accepting from a Health Service Provider or a health organisation (or from another person on behalf of such a person) a benefit as inducement, consideration or reward for:

(i) referring another person to the Health Service Provider or health organisation; or

(ii) recommending another person use any health service provided by the Health Service Provider or health organisation or consult with the Health Service Provider or health organisation in relation to a health matter;

(f) accepting from a person who supplies a health product (or from another person on behalf of the supplier) a benefit as inducement, consideration or reward for recommending that another person use the health product, but does not include accepting a benefit that consists of ordinary retail conduct;

(g) offering or giving a person a benefit as inducement, consideration or reward for the person:

(i) referring another person to the Health Care Worker; or

(ii) recommending to another person that the person use a health service provided by the Health Care Worker or consult the Health Care Worker in relation to a health matter;

(h) referring a person to, or recommending that a person use or consult:

(i) another Health Service Provider or a health organisation; or

(ii) a health service; or

(iii) a health product,

if the Health Care Worker has a financial interest in giving that referral or recommendation, unless the Health Care Worker discloses the nature of the interest to the person before or at the time of giving the referral or recommendation;

(i) engaging in overservicing;

(j) permitting an assistant employed by the Health Care Worker (in connection with the Health Care Worker's professional practice) who is not appropriately qualified, skilled or experienced to provide health services to patients in respect of matters requiring professional discretion or skill;

(k) any other improper or unethical conduct relating to the practice or purported practice of the Health Care Worker's profession.

For the purposes of By-law 15 a Health Care Worker has a "financial interest" in giving a referral or recommendation:

(a) if the Health Service Provider or health organisation, or the supplier of the health product, to which the referral or recommendation relates is a public company and the Health Care Worker holds 5% or more of the issued share capital of the company;

(b) if the Health Service Provider or health organisation, or the supplier of the health product, to which the referral or recommendation relates is a private company and the Health Care Worker has any interest in the company;

(c) if the Health Service Provider or health organisation, or the supplier of the health product, to whom the referral or recommendation relates is a natural person who is a partner of the Health Care Worker; or

(d) in any circumstances determined by the Board which are the same as or similar to those prescribed under section 139B(2)(d) of the National Regulation Laws in respect of a Registered Health Practitioner.

A reference in this By-law 15 to a referral or recommendation that is given to a person includes a referral or recommendation that is given to more than one person or to persons of a particular class.

In this By-law 15:

benefit means money, property or anything else of value;

health organisation means a body (other than an individual) that provides a health service;

health product means a pharmaceutical or other product used for health purposes;

overservicing by a Health Care Worker means that person in the course of practising their profession:

(a) provides a service in circumstances in which provision of the service is unnecessary, not reasonably required or excessive; or

(b) would be engaging in conduct prescribed by the regulations under the National Regulation Laws as constituting overservicing if the Health Care Worker was a Registered Health Practitioner;

recommend a health product includes supply or prescribe the health product; and

supply includes sell

16. Suspension and Termination - General

16.1 Serious Sex or Violence Offences

16.1.1. The Chief Executive Officer must suspend and the Board must terminate, the Accreditation of an Accredited Person who has a criminal finding against them (whether before or during his or her Accreditation) of a Serious Sex or Violence Offence.

16.1.2. This By-law 16 does not apply to an Accredited Person if before being Accredited:

(a) that person notified the Chief Executive Officer in writing of the fact of the criminal finding;

(b) the Chief Executive Officer reported the criminal finding to the Board; and

(c) the Board notified the Chief Executive Officer in writing that it consented to the Accreditation of the Accredited Person.

16.1.3. This By-law 16.1 extends to a criminal finding that occurred before the commencement of this By-law 16.

16.2 Patients' interest's paramount

The protection of patients and their wellbeing is to be the paramount consideration in deciding whether to terminate or suspend an Accredited Person's Accreditation.

16.3 Other rights

Nothing in this By-law 16 affects any other rights that the Hospital Licensee may have in relation to an Accredited Person in respect of any Suspension Event or Termination Event.

16.4 Notification of other bodies

The Chief Executive Officer or the Board may:

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

(b) notify the operator of any other Health Facility of the suspension or termination of Accreditation of an Accredited Person, the imposition of a Special Condition or the amendment of an Accredited Person's Scope of Clinical Practice.

16.5 Other proceedings

16.5.1. If an Accredited Person's behaviour constitutes an offence under any statute and also constitutes Professional Misconduct or Unsatisfactory Professional Conduct, the fact that proceedings for an offence have been taken in relation to the behaviour does not prevent action being taken under these By-laws for the same behaviour.

16.5.2. If a person's behaviour may be dealt with by a Health Complaints Entity under the law of any jurisdiction, the fact that the behaviour has been dealt with by the Health Complaints Entity does not prevent action being taken under these By-laws for the same behaviour.

16.6 Transition Provisions

16.6.1. The provisions of these By-laws relating to suspension or termination of Accreditation will only apply to the extent that the events or circumstances giving rise to a right to suspend or terminate occurred after these By-laws came into effect or, if they occurred before that time, action has not commenced under the superseded By-laws of the Hospital Licensee to suspend or terminate.

16.6.2. All other cases must be dealt with in accordance with the By-laws of the Hospital Licensee in effect at the time the relevant event or circumstance occurred as if those superseded By-laws were still in effect.

16.7 **Future Accreditations**

If a person is no longer Accredited, the Board may:

(a) decide that if the person were still Accredited the Board would have terminated the person's Accreditation; and

(b) if the Board would have terminated the person's Accreditation, decide that the person is disqualified from being Accredited for a specified period or until specified conditions have been complied with.

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17. Appeal

17.1 **Appealable Decisions**

17.1.1. A decision by:

(a) the Board to amend an Accredited Medical Practitioner's Scope of Clinical Practice or to impose a Special Condition under By-law 12 (except where the Special Condition is imposed by agreement with the Accredited Medical Practitioner);

(b) the Chief Executive Officer to suspend an Accredited Medical Practitioner's Accreditation under By-law 13;

(c) the Chief Executive Officer to impose a Special Condition on reinstatement of an Accredited Medical Practitioner's Accreditation under By-law 13 (except where the Special Condition is imposed by agreement with the Accredited Medical Practitioner); or

(d) the Board to terminate the Accredited Medical Practitioner's Accreditation under By-law 14,

may be appealed by the Accredited Medical Practitioner in accordance with this By-law 17.

17.1.2. An Accredited Medical Practitioner cannot appeal against a decision under these By-laws to suspend or terminate his or her Accreditation because the Accredited Medical Practitioner has been found guilty of a Serious Sex or Violence Offence.

17.2 **Reasons Statement**

17.2.1. The Chief Executive Officer must, if requested by the appellant, provide to the appellant a short statement of reasons for the Appealed Decision setting out:

(a) the decision;

(b) the reasons for the decision; and

(c) the findings on material questions of fact relevant to the decision.

17.2.2. If the basis of, and reasons for, the decision which is the subject of the appeal is apparent from the notice, the Chief Executive Officer may decide that the notice itself will be taken to be the statement of reasons.

17.2.3. If the Appealed Decision was substantially based on a recommendation of the Medical Advisory Committee, the chair of the Medical Advisory Committee must provide any documentation, information and co-operation necessary to enable the Chief Executive Office to prepare the statement of reasons.

17.2.4. The Appeal Committee must provide the appellant with a reasonable opportunity to consider the statement of reasons and make submissions to the Appeal Committee about the Appealed Decision.

17.3 **Lodgement of appeals**

17.3.1.

(a) Subject to By-law 17.1.2 if an Accredited Medical Practitioner wishes to appeal an Appealable Decision, the Accredited Medical Practitioner must lodge a notice of appeal in writing with the Chief Executive Officer within 10 Working Days from the later of:

(i) the date of being notified of that decision; or

(ii) being provided with the Reasons Statement.

(b) A notice of appeal must set out all relevant details of the basis for appeal and clearly identify the applicable grounds of appeal.

17.3.2. The Chief Executive Officer must, within 10 Working Days of receiving a notice of appeal, refer a notice of appeal lodged in accordance with this By-law 17 to the Board.

17.3.3. The Chief Executive Officer may extend the time for lodging a notice of an appeal if he or she is satisfied that the affected Accredited Medical Practitioner has a reasonable excuse for not lodging his or her notice of appeal within that 10 Working Day period.

17.3.4. The Board may refuse to deal with the appeal if it is satisfied that the appeal is frivolous, vexatious, not made in good faith, is lacking in substance or otherwise has no reasonable chance of success.

17.4 **Appeal Committee**

17.4.1. The Board must within a reasonable time convene a committee to deal with the appeal.

17.4.2. The Appeal Committee must comprise:

(a) an appointee of the Board;

(b) an appointee of the Medical Advisory Committee;

(c) an appointee of the Vice-Chancellor;

(d) an appointee of the executive dean of the Faculty; and

(e) an appointee of the relevant professional college of the appellant.

17.4.3. If there is a failure to appoint any person as set out in By-law 17.4.2 within a period specified by the Board from receiving the notice then the balance of persons comprising the Appeal Committee may proceed provided there is a minimum of 3 people on the Appeal Committee.

17.5 **Chair**

The appointee of the Board will be the chair of the Appeal Committee.

17.6 **Appeal Grounds**

The permitted grounds of appeal are as follows:

(a) in all cases - procedural fairness appropriate to the circumstances was not afforded to the appellant in respect of the Appealed Decision resulting in substantial injustice to the appellant; or

(b) in the case of a finding of Professional Misconduct or Unsatisfactory Professional Conduct the Appealed Decision was not the correct or preferable decision in the circumstances.

17.7 **Submissions**

17.7.1. The appellant may provide written submissions to the Appeal Committee about the Appealed Decision.

17.7.2. The Appeal Committee may invite the appellant to make oral submissions to the Appeal Committee about the Appealed Decision.

17.7.3. The appellant is not entitled to have legal or other representation at any hearing of an appeal but may have a support person present.

17.8 **Determination of the appeal**

17.8.1. The Appeals Committee must determine the appeal having regard to the material before the Appeal Committee, including the Reasons Statement and any submissions of the appellant.

17.8.2. The Appeals Committee may:

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

(b) if it considers that the decision was not the correct or preferable decision, amend the decision which was the subject of the appeal; or

(c) if it considers that procedural fairness was not afforded, resulting in substantial injustice to the appellant, refer the matter to the decision maker for reconsideration of the decision.

17.8.3. The decision of the Appeals Committee is binding on the appellant.

17.9 **Notification of determination**

The Chief Executive Officer must notify the appellant of the Appeals Committee's decision in writing within 10 Working Days of the decision being made.

17.10 **Appeal Limit**

An Accredited Person has no right to appeal any decision, finding or recommendation of the Board, the Chief Executive Officer or any Relevant Committee except in accordance with this By-law 17.

17.11 **Effect of decision pending appeal**

17.11.1. An appeal under this By-law 17 of a decision does not affect the operation of that decision or prevent the taking of action to implement that decision unless the Chief Executive Officer suspends the operation of the decision until the outcome of the appeal is known.

17.11.2. The Chief Executive Officer may suspend the operation or the implementation of an Appealed Decision on his or her own initiative or upon the application of the Accredited Medical Practitioner.

17.11.3. The Chief Executive Officer in making a decision as to whether to suspend the operation or implementation of the Appealed Decision must have regard to whether it is necessary or desirable to do so in all the circumstances including for the purpose of ensuring:

(a) that health services are provided at the Hospital safely and are of an appropriate quality;

(b) the safety and wellbeing of patients and the Hospital, the officers and staff of the Hospital Licensee, students and other Accredited Persons, including the need to prevent any harassment or intimidation of any person;

(c) that the efficient operation and management of the Hospital is not hindered;

(d) the protection of property or any person; or

(e) the protection of the reputation of the Hospital Licensee or the University.

Part C Organisation of the Medical Staff

18. Clinical Programs

18.1 Establishment

18.1.1. The Board may establish Clinical Programs of Accredited Persons with a membership determined by reference to particular qualifications, medical or surgical specialties or health services.

18.1.2. The Board may establish sub-departments within Clinical Programs by reference to particular qualifications, medical or surgical specialties or clinical services but a sub-department will not be a Clinical Program for the purposes of these By-laws.

18.2 Meetings

The members of a Clinical Program established under these By-laws must meet with sufficient frequency to discharge its business and must report quarterly to the Medical Advisory Committee regarding the Clinical Program's activities.

18.3 Clinical Program Head

Each Clinical Program Head must be an Accredited Medical Practitioner appointed by the Board and approved by MUCA.

18.4 Role of Clinical Program Head

The function of each Clinical Program Head is to:

(a) advise the Chief Executive Officer and to facilitate consultation with the members of the Clinical Program in relation to matters concerning the Clinical Program;

(b) facilitate, support and promote relevant professional, clinical, education and research activities of the Clinical Program;

(c) provide leadership of the clinical governance of the Clinical Program and, to the extent applicable, the Hospital;

(d) participate in, and represent the Clinical Program on, appropriate Hospital committees;

(e) consult with the Medical Advisory Committee and the Chief Executive Officer in relation to the Accreditation of Accredited Medical Practitioners and any decision about the

Scope of Clinical Practice of Accredited Medical Practitioners in accordance with these By-laws;

(f) facilitate regular meetings and active regular participation in quality assurance activities, education and research for the Clinical Program;

(g) support the development of the Clinical Program, its members and the Hospital;

(h) enhance the effectiveness of Clinical Program activities and promote cooperation between Clinical Programs;

(i) monitor the performance of the Clinical Program members;

(j) oversee the Clinical Program's performance;

(k) oversee the clinical activities of the Clinical Program members;

(l) advise the Board and the Chief Executive Officer on matters concerning the Clinical Program and related activities of the Clinical Program; and

(m) consider and report to the Board on any matter referred to it by the Board;

and any other functions determined from time to time by the Board after consultation with MUCA.

18.5 **Medical Advisory Committee Consultation**

A Clinical Program Head may consult with and take advice from the Medical Advisory Committee.

18.6 **Reports**

18.6.1. A Clinical Program Head must comply with the lawful and reasonable directions of the Director Medical Services relating to the admission of and provision of health services to patients at the Hospital.

18.6.2. Each Accredited Person must comply with the lawful and reasonable directions of his or her Clinical Program Head relating to the activities of the relevant Clinical Program and its members.

19. Medical Advisory Committee

19.1 **Appointment of the Medical Advisory Committee**

The Board must appoint a medical advisory committee for the Hospital in accordance with the PHF Act and these By-laws.

19.2 **Function**

19.2.1. The Medical Advisory Committee has the following functions:

(a) to advise the Board and the Chief Executive Officer on the Accreditation of Medical Practitioners and their Scope of Clinical Practice and the delineation of their clinical responsibilities;

(b) to advise the Board on matters concerning clinical practice at the Hospital;

(c) to advise the Board on matters concerning patient care and safety at the Hospital;

(d) to be responsible for any other matter that may be prescribed by law;

(e) to consider, and report to the Board or the Chief Executive Officer on, any matter relating to the Hospital referred to it by the Board or the Chief Executive Officer, as the case requires; and

(f) any other functions determined from time to time by the Board.

19.2.2. The Medical Advisory Committee must report promptly to the Board any matters known to it which is likely to have a material and adverse effect on the health or safety of patients at the Hospital.

19.3 **Membership**

The Medical Advisory Committee must comprise:

(a) at least 7 Medical Practitioners (each of whom holds general or specialist registration in the medical profession under Part 7 of the National Regulation Law and are Accredited Medical Practitioners) appointed by the Board and must include each Clinical Program Head or a member of each Clinical Program;

(b) the Managing Director of MUCA or their nominee;

(c) one Medical Practitioner who holds general or Specialist registration in the medical profession under Part 7 of the National Regulation Law and is an Accredited Medical Practitioner, appointed by the executive dean of the Faculty;

(d) the Chief Executive Officer;

(e) the Director of Medical Services; and

(f) the Director of Nursing.

19.4 **Term**

The members of the Medical Advisory Committee appointed by the Board must be appointed for a period of one year and are eligible for, but not entitled to, re-appointment to the Medical Advisory Committee.

19.5 **Vacancies**

19.5.1. The appointer of any appointed member of the Medical Advisory Committee may appoint an Accredited Medical Practitioner to fill any casual vacancy created by any of their appointees to the Medical Advisory Committee ceasing to be members.

19.5.2.

(a) If at any time the position of Clinical Program Head for any Clinical Program is vacant, then the Board must appoint another member of that Clinical Program to be on the Medical Advisory Committee until a replacement Clinical Program Head is appointed.

(b) A person appointed by the Board must be a Medical Practitioner who holds general or specialist registration in the medical profession under Part 7 of the National Regulation Law and is an Accredited Medical Practitioner.

19.6 **Sub-committees**

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

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

19.6.3. The Chief Executive Officer may decide whether a sub-committee is only to advise the Medical Advisory Committee or is to exercise a delegated function of the Medical Advisory Committee.

19.7 **Resignation from the Medical Advisory Committee**

A member of the Medical Advisory Committee may resign from the Medical Advisory Committee by giving at least 30 days' notice in writing to the Chief Executive Officer.

19.8 **Meetings**

19.8.1. Ordinary meetings of the Medical Advisory Committee must be held not less than 4 times a year at a time and place to be determined by the chair in consultation with the Chief Executive Officer.

19.8.2. The quorum for a meeting of the Medical Advisory Committee will be five Accredited Medical Practitioners.

19.9 **Extraordinary Meetings**

19.9.1. Any member of the Medical Advisory Committee may in an emergency convene an extraordinary meeting of the Medical Advisory Committee by giving notice to the other members.

19.9.2. A notice of a meeting must specify the place, and time of meeting and, must state the general nature of the business to be transacted at the meeting.

19.10 **No representation**

A member of the Medical Advisory Committee does not represent, and must not purport to represent in any way the Board, the Hospital Licensee, the University or the Faculty except with the prior, express written permission of the Board, Chief Executive Officer, Vice-Chancellor or executive dean of the Faculty, as the case requires.

Part D Research and New Clinical Procedures

20. Research

20.1 **Approval for medical research**

20.1.1. An Accredited Person must not undertake medical research at the Hospital, or involve any patient in medical research at the Hospital, unless:

(a) each Health Service Provider involved in the research is Accredited;

(b) the medical research is within the Scope of Clinical Practice of each Accredited Medical Practitioner involved in the research;

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

(d) the Accredited Medical Practitioner has notified (in any form required by the Chief Executive Officer):

(i) the Chief Executive Officer;

(ii) the Medical Advisory Committee; and

(iii) any person required under a policy of the University or the Hospital Licensee; and

(e) the Chief Executive Officer is satisfied that appropriate insurance is in place in relation to the research and that related risks have been identified and addressed appropriately.

20.2 **Review by Medical Advisory Committee**

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

20.3 **Compliance with conditions**

Medical research must be conducted in accordance with any conditions subject to which approval of the research is given by the Macquarie University Human Research Ethics Committee.

21. New Clinical Procedures

21.1 **Appointment of the CIA Committee**

21.1.1. The Chief Executive Officer must establish a clinical innovation and audit committee for the Hospital in accordance with these By-laws.

21.1.2. The CIA Committee has the following functions:

(a) to review proposed New Clinical Procedures and recommend whether or not they should be permitted at the Hospital;

(b) to otherwise advise the Chief Executive Officer on the introduction of New Clinical Procedures to the Hospital and related matters; and

(c) any other functions determined from time to time by the Chief Executive Officer.

21.1.3. The CIA Committee must comprise:

(a) the Director of Medical Services;

(b) the Director of Nursing;

(c) the Chief Financial Officer of the Hospital Licensee; and

(d) at least 3 but not more than 7 other Accredited Medical Practitioners appointed by the Chief Executive Officer.

21.1.4. The members of the CIA Committee must be appointed for a period of 3 years and are eligible for, but not entitled to, re-appointment to the CIA Committee.

21.1.5. The Board may appoint an Accredited Medical Practitioner to fill any casual vacancy.

21.1.6. A member of the CIA Committee appointed by the Board may resign from the CIA Committee by giving at least 30 days' notice in writing to the Chief Executive Officer.

21.1.7. The Director of Medical Services is to be the chair of the CIA Committee, or if he or she is unable or unwilling to act at any time, a committee member appointed by the committee.

21.2 **Application to introduce a New Clinical Procedure**

21.2.1. Only an Accredited Medical Practitioner may propose the introduction of a New Clinical Procedure.

21.2.2. An Accredited Medical Practitioner who proposes to introduce a New Clinical Procedure must:

(a) apply to the Chief Executive Officer in writing for approval to do so; and

(b) provide any information required by the Chief Executive Officer about the New Clinical Procedure.

21.3 **Referral to Medical Advisory Committee**

21.3.1. The Chief Executive Officer:

(a) must refer any proposal to introduce a New Clinical Procedure to the CIA Committee for its review and recommendations; and

(b) may refer the proposal to the Medical Advisory Committee for its review and recommendations.

21.3.2. The CIA Committee and the Medical Advisory Committee must in respect of any New Clinical Procedure referred to it, make recommendations to the Chief Executive Officer in relation to:

(a) the introduction of the New Clinical Procedure at the Hospital; and

(b) whether the New Clinical Procedure is within the use of Scope of Clinical Practice of the Accredited Medical Practitioner who proposes to use it.

21.4 **Prohibition**

An Accredited Medical Practitioner must not use or involve any patient in a New Clinical Procedure at the Hospital unless:

(a) the New Clinical Procedure is within the Accredited Medical Practitioner's Scope of Clinical Practice;

(b) the Chief Executive Officer is satisfied that appropriate insurance cover is in place for the New Clinical Procedure; and

(c) the Chief Executive Officer has approved in writing the introduction of the New Clinical Procedure.

21.5 **Relevant Issues**

In determining whether to approve the introduction of a New Clinical Procedure, the Chief Executive Officer may have regard to:

(a) any finding or recommendation of the CIA Committee or the Medical Advisory Committee;

(b) the financial and operational implications of allowing the introduction of the New Clinical Procedure; and

(c) any other matter he or she considers appropriate.

Part E Management

22. Hospital Regulations

22.1 **Making regulations**

The Board may:

(a) make and publish any Hospital Regulations relating to the management and operation of the Hospital; and

(b) suspend the operation of or amend any Hospital Regulations.

22.2 **Limitation**

The Hospital Regulations must be consistent with these By-laws and if they are not then these By-laws will prevail to the extent of the inconsistency.

23. Complaints

23.1 **Complaint procedures**

23.1.1. The Chief Executive Officer may establish procedures for dealing with complaints relating to the operation of the Hospital including the provision of health services at the Hospital by Accredited Persons and other persons.

23.1.2. The procedures may be different for:

(a) Accredited Persons and other persons (including staff of the Hospital Licensee or MUCA);

(b) different categories of Accredited Persons;

(c) Accredited Persons who are accused of Professional Misconduct or Unsatisfactory Professional Conduct which is also unlawful or which may give rise to criminal or civil liability;or

(d) Accredited Persons who are the subject of a complaint to a Health Complaints Entity.

23.1.3. The Chief Executive Officer may from time to time suspend the operation of, revoke or amend the complaint procedures.

23.2 **Publication**

23.2.1. The Chief Executive Officer must ensure that the complaint procedures are published on the Hospital's website.

23.2.2. Failure to comply with By-law 23.1 does not invalidate a decision, procedure or direction contemplated by these By-laws.

23.2.3. All Accredited Persons are bound by the complaint procedures and must co-operate in their implementation.

Part F General Provisions

24. Confidentiality

24.1 **Obligation of confidentiality**

An Accredited Person must not:

(a) use or disclose Confidential Information; or

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

other than:

(i) for the purpose of complying with any obligation or carrying out a function of that person under these By-laws;

(ii) with the consent of the person from whom the information was obtained;

(iii) for the purposes of any legal proceedings arising out of these By-laws or of any report of any such proceedings;

(iv) with other lawful excuse; or

(v) in any other circumstances approved by the Board.

24.2 **Exceptions to obligations of confidentiality**

By-law 24.1 does not apply where:

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

(b) disclosure of the relevant information is required to comply with an applicable law; or

(c) disclosure of the relevant information is required by, or contemplated by, these By-laws.

24.3 **Specific confidentiality undertakings**

An Accredited Person or any other person bound by these By-laws, if required by the Hospital Licensee, must sign a binding confidentiality undertaking giving effect to or supplementing this By-law 24.

25. Delegation of functions

25.1 **By Relevant Officer**

A Relevant Officer may delegate their functions and powers under these By-laws or otherwise authorise the carrying out of those functions or powers to:

(a) any suitably qualified officer or staff member of the Hospital Licensee, the University or MUCA; or

(b) a person of a class approved by the Board.

25.2 **By Board to Committee**

A decision-making power or function of the Board under these By-laws, may be delegated to a committee of the Board.

25.3 **Limited**

Nothing in this By-law 25 authorises a Relevant Officer or the Board to delegate the whole of his, her or its functions.

25.4 **Directors**

The Board may give any direction to a Relevant Officer concerning delegations that the Board thinks appropriate.

25.5 **Interpretation Act application**

The provisions of section 49 of the *Interpretation Act 1987* will be taken to be incorporated into these By-laws, with necessary adaptations, as if these By-laws were a statute of New South Wales.

26. Disputes

26.1 Board to determine

Any dispute or difference relating to:

(a) the functions or powers of any Relevant Committee;

(b) the validity of the proceedings of any Relevant Committee; or

(c) the procedures for Accreditation, Credentialing and determining the Scope of Clinical Practice of an Accredited Medical Practitioner,

may be determined by the Board.

26.2 Board decision final

Subject to any rights of an Accredited Persons under By-law 17, the Board's decision in relation to the dispute or difference will be final and binding on Accredited Persons.

26.3 Recording of proceedings

The Chief Executive Officer may cause an audio or video recording to be made of any proceedings of the Chief Executive Officer, the Board or any Relevant Committee relating to the exercise or proposed exercise of a function under these By-laws in respect of an Accredited Person:

(a) during which the Accredited Person or the Accredited Person's support person is present; or

(b) during which a person, other than a member of the Board or the Chief Executive Officer or a Hospital Licensee staff member, provides information relating to the proceeding of the Chief Executive Officer, Board or Relevant Committee.

27. Service of notices and other communications

27.1 Legible and in English

Any written communication relating to these By-laws must be legible and in the English language.

27.2 To the Hospital

Any communication relating to these By-laws to the Chief Executive Officer, the Board or the Hospital Licensee may be given by being:

(a) delivered personally to the Chief Executive Officer;

(b) left at the office of the Chief Executive Officer or sent by prepaid post or courier to the Hospital, addressed to the Chief Executive Officer; or

(c) sent to the Chief Executive Officer by email or other electronic means to any email address that is published by the Hospital Licensee as the email address of the Chief Executive Officer.

27.3 **To Accredited Persons**

Any communication relating to these By-laws to an Accredited Person may be given by being:

(a) delivered personally to that person;

(b) left at or sent by post to:

(i) the most recent address of that person as it appears on the records of the Hospital Licensee; or

(ii) such other address of that person as appears to the sender to be an address where that person resides or works; or

(c) in the case of an Accredited Person, sent to the University email address (if any) of that person or to an email address that has been given by that person for the purpose of receiving communications or which is otherwise the last email address known to the Hospital Licensee.

27.4 **Timing of Receipt**

Any communication will be taken to have been given:

(a) in the case of sending by prepaid post or courier- if posted or couriered in the Commonwealth of Australia to an address in the Commonwealth of Australia, within three Working Days of posting or being given to the courier and in any other case within five Working Days of posting by airmail or being given to the courier; and

(b) in the case of sending by email – at 9.00 am Sydney time on the next Working Day after it is sent.

27.5 **Vulnerable recipients**

(a) If the Chief Executive Officer is satisfied that giving a person a notification, information or anything else contemplated by these By-laws may adversely affect the physical or mental health of that person, the Chief Executive Officer is not obliged to give it to that person directly but may give it to a Medical Practitioner who is nominated by that person.

(b) If requested by the Chief Executive Officer the relevant person must promptly nominate a Medical Practitioner by notifying the Chief Executive Officer in writing of the name, address, phone number and email address of that Medical Practitioner.

(c) This By-law 27.5 applies notwithstanding any other provision of these By-laws.

28. Governing law and jurisdiction

28.1 **New South Wales Law**

These By-laws are governed by and must be interpreted in accordance with the laws of New South Wales and the applicable federal laws of the Commonwealth of Australia.

28.2 **New South Wales Court Jurisdiction**

Each Accredited Person must irrevocably and unconditionally submit to the exclusive jurisdiction of the courts of New South Wales and the federal courts of the Commonwealth of Australia and waive any right to object for any reason to any proceedings being brought in any of those courts.

Part G Interpretation Related Matters

29. Dictionary and Interpretation Rules

29.1 Definitions

The following definitions apply in these By-laws:

Accreditation means being approved pursuant to these By-laws to provide health services to patients at the Hospital and includes any renewal of Accreditation.

Accreditation Applicant means an applicant for Accreditation.

Accreditation Standard means a standard used to assess whether an Accreditation Applicant has the qualifications, professional training, skills and experience necessary to be Accredited.

Accredited Allied Health Practitioner means an Allied Health Practitioner who has been Accredited.

Accredited Dentist means a Dentist who has been Accredited.

Accredited Health Care Worker means a Health Care Worker who is Accredited.

Accredited Health Practitioner means a Health Practitioner who is Accredited.

Accredited Medical Practitioner means a Medical Practitioner who is Accredited.

Accredited Nurse means a Nurse who is Accredited.

Accredited Persons means

(a) Accredited Medical Practitioners;

(b) Accredited Dentists;

(c) Accredited Allied Health Practitioners;

(d) Accredited Nurses; and

(e) Accredited Health Care Workers.

Adjudication Body has the meaning given in the *National Regulation Law*.[2]

Allied Health Practitioner means a Health Practitioner, other than a Medical Practitioner or Dentist, currently registered to practice under the National Regulation Law.

Appeal Committee means a committee convened under By-law 17.4.

Appealable Decision means a decision referred to in By-law 17.1.

Appealed Decision means a decision which is the subject of an appeal under By-law 17.

Associate means, in respect of any person, any of the following:

(a) the spouse, de facto partner, parent, child, brother or sister, business partner or friend of the Accredited Person;

[2] *National Regulation Law*, section 5.

(b) the spouse, De Facto Partner, parent, child, brother or sister, business partner or friend of a person referred to in paragraph (a) if that relationship is known to the Accredited Person; or

(c) any other person who is known to the Accredited Person for reasons other than that person's connection with the Hospital Licensee or that person's public reputation.

Board means the board of directors of the Hospital Licensee.

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

Chief Executive Officer means the person appointed by the Board as the chief executive of the Hospital Licensee including, if the context permits, a person authorised by the Board to act in that position.

Chief Finance Officer means the person appointed by the Board as the chief financial officer of the Hospital Licensee including, if the context permits, a person authorised by the Board to act in that position**.**

Clinic means the building known as Macquarie University Clinic at 2 Technology Place, Macquarie University, NSW.

Clinical Program means a group or cohort of Accredited Persons at the Hospital established pursuant to these By-laws for the purposes of management of a particular area of clinical practice at the Hospital.

CIA Committee means the committee contemplated by By-law 21.

Clinical Program Head means the person appointed to manage and provide clinical leadership for a Clinical Program.

Confidential Information means information which is stated to be confidential or which a reasonable person in the circumstances would understand to be confidential and includes any proceedings contemplated by these By-laws relating to Accreditation of any person and the proceedings of the Board and each committee or sub-committee established pursuant to these By-laws.

Conflict of Interest means, in respect of a person and a matter, that:

(a) a determination in the matter may result in a detriment to or a benefit to that person or an Associate of that person;

(b) that person has a duty to another person which conflicts with the obligation of that person to the Hospital Licensee,

(c) but, is taken not to have a conflict of interest if the interest or duty:

(d) arises only because the person is an Accredited Person; or

(e) in respect of a matter that is so remote or insignificant that it could not reasonably be regarded as likely to influence any decision the person might make in relation to the matter.

Credentialing means the process used by the Hospital Licensee to verify and assess the identity, qualifications, experience and professional standing of Health Service Providers for the purpose of evaluating their competence, performance and professional suitability to provide health services to patients at the Hospital.

Criminal History means in respect of a person the following:

(a) every conviction of the person for a criminal offence anywhere and at any time;

(b) every plea of guilty or criminal finding by a court of the person for a criminal offence anywhere and at any time; and

(c) every charge made against the person for a criminal offence anywhere and at any time.

De facto Partner has the same meaning as in section 21C of the *Interpretation Act 1987.*

Dentist means a person registered under the National Regulation Law who practices in the dental health profession.

Director of Medical Services means the senior executive of the Hospital Licensee, who reports to the Chief Executive Officer and who is responsible for the management of the provision of health services in the Hospital.

Director of Nursing means the senior executive of the Hospital Licensee who reports to the Chief Executive Officer and who is responsible for the management of the provision of nursing services in the Hospital.

Faculty means the Faculty of Medicine and Health Sciences of the University.

General Conditions means the general conditions of Accreditation applying to each Accredited Person which are set out in Schedule 1.

Health Assessment means an assessment of a person to determine whether the person has an Impairment and includes a medical, physical, psychiatric or psychological examination or test of the person.

Health Care Worker means:

(a) a natural person who provides a health service who is not registerable under the National Regulation Law; and

(b) who holds current full membership with an appropriate professional association or body which requires its members to comply with the Code of Conduct for such persons (made under Schedule 3 of the *Public Health Regulation* 2012).

Health Complaints Entity means an entity:

(a) that is established by or under a statute of any jurisdiction; and

(b) whose functions include conciliating, investigating and resolving complaints made against Health Service Providers.

Health Facility means premises at which any person is admitted, provided with health services and then discharged and includes a hospital.

Health Practitioner means a person who is registered under the National Regulation Law as a health practitioner.[3]

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

Health Service Providers means:

(a) Medical Practitioners;

(b) Dentists;

(c) Nurses;

(d) Health Care Workers; and

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[3] *National Regulation Law*, section 5.

(e) Allied Health Practitioners

Hospital means Macquarie University Hospital at 3 Technology Place, Macquarie University, NSW and, if the context permits, includes the Clinic.

Hospital Licensee means MUH Operations No. 2 Pty Limited.

Hospital Medical Officer means an Accredited Medical Practitioner who is employed or contracted for service by the Hospital Licensee or MUCA to assist Specialist Practitioners in the care of patients, and includes junior medical officers, registrars and career medical officers.

Hospital Regulations means these By-laws and the policies, procedures, protocols and guidelines published from time to time by the Hospital Licensee.

Human Research Ethics Committee means an ethics committee of the University constituted in accordance with National Health and Medical Research Council *National Statement on Ethical Conduct in Human Research* (as amended from time to time)[4] and includes the Research Ethics Committee of the University.

Impairment means in respect of any Accredited Person or an applicant for Accreditation, that the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect that person's capacity to practise their profession or occupation and to train and teach.

Independent Reviewer means a reviewer contemplated by By-law 12.2 who is independent of the Hospital Licensee and University and who has appropriate skills, expertise and professional training in the relevant Scope of Clinical Practice to carry out the review.

Medical Advisory Committee means the medical advisory committee of the Hospital, contemplated by these By-laws.

Medical Observer means a person who only observes the provision of health services and includes a person who is a medical student or graduate from outside Australia who wishes to become familiar with medical practice in Australia or is preparing for examinations in Australia for the purpose of becoming a Medical Practitioner.

Medical Practitioner means:

(a) an individual who has general registration under the National Regulation Law in the medical profession and who practices in the medical profession;

(b) an individual who has specialist registration under the National Regulation Law in the medical profession and who practices in the medical profession;

(c) an individual who is provisionally registered under the National Regulation Law and is undertaking a period of supervised practice that the individual requires to be eligible for general registration under the National Regulation Law in the medical profession; or

(d) an individual who has limited registration under the National Regulation Law in the medical profession and who practices in the medical profession; or

as the context requires.

MUCA means Macquarie University Clinical Associates Limited.

National Board has the meaning given in the National Regulation Law[5] and includes:

(a) the Medical Board of Australia; and

[4] National Statement on Ethical Conduct in Human Research 2007 (Updated March 2014).
[5] *National Regulation Law*, section 5.

(b) the Dental Board of Australia.

National Regulation Law means the *Health Practitioner Regulation National Law 2009* (NSW).

New Clinical Procedure means a medical or surgical treatment, procedure or other intervention which has not previously been carried out at the Hospital and includes a treatment, procedure or other intervention which is experimental.

Nurse means an individual who is registered under the National Regulation Law to practice as:

(a) a registered nurse;

(b) a perioperative nurse - surgical assistant; or

(c) a nurse practitioner.

Objects means the objects set out in By-law 1.

PHF Act means the *Private Health Facilities Act 2007* (NSW).

Privacy Laws means the *Privacy Act 1988* (Cth), the *Health Records and Information Privacy Act 2002* (NSW) and any other legislation or binding schemes applicable to the Hospital or Accredited Practitioners relating to the privacy of personal information and health records.

Professional Misconduct has the meaning given in the National Regulation Law[6].

Reasons Statement means a statement of reasons contemplated by By-law 17.2.1.

Registered Health Practitioner means a person who is registered under the National Regulation Law as a health practitioner.[7]

Relevant Committee means any committee or sub-committee or other group of individuals contemplated by these By-laws including the Medical Advisory Committee.

Relevant Officer means:

(a) the Chief Executive Officer;

(b) a Clinical Program Head;

(c) the Director of Medical Services; and

(d) the Director of Nursing.

Required Insurance means professional indemnity insurance that complies with any applicable requirements published by the National Board and the requirements of clause 3.1 of the General Conditions.

Scope of Clinical Practice means the extent of clinical practice and health services that an Accredited Medical Practitioner is authorised by the Hospital Licensee to undertake or provide at the Hospital.

Serious Sex or Violence Offence means an offence involving sexual activity, acts of indecency, physical violence or the threat of physical violence against any person or animal that:

(a) if committed in New South Wales, is punishable by imprisonment; or

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[6] *National Regulation Law*, section 139E

[7] *National Regulation Law*, section 5.

(b) if committed elsewhere than in New South Wales, would have been an offence punishable by imprisonment if committed in New South Wales.

Special Conditions means conditions of Accreditation, other than the General Conditions, determined by the Board or the Chief Executive Officer, as the case requires, to apply:

(a) on Accreditation of an Accredited Person;

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

(c) on reinstatement of an Accredited Person's Accreditation following suspension of Accreditation.

Suspension Events means, in respect of any Accredited Person, the following events or circumstances:

(a) any event or circumstance which adversely affects patient safety or wellbeing at the Hospital;

(b) any Termination Event;

(c) any complaint or allegation is made to the Hospital Licensee or any Health Complaints Entity to the effect that the Accredited Person is guilty of Professional Misconduct, or Unsatisfactory Professional Conduct.

(d) any complaint or allegation is made to the Hospital Licensee or any Health Complaints Entity to the effect that the Accredited Person has an Impairment; or

(e) the Accredited Person is charged with an offence which:

(i) if committed in New South Wales, is punishable by imprisonment; or

(ii) if committed elsewhere than in New South Wales, would have been an offence punishable by imprisonment if committed in New South Wales.

Termination Events means the following events or circumstances in relation to an Accredited Person:

(a) the Board or the Chief Executive Officer, as the case requires, are satisfied that the Accredited Person is guilty of Professional Misconduct or Unsatisfactory Professional Conduct.

(b) in the case of a Health Care Worker and in addition to any other requirements set out in these By-laws the Board or CEO are satisfied that the Accredited Person has engaged in unacceptable practices whilst practising at the Hospital (as defined in By-Law 15).

(c) if the Accredited Person is registered as a Health Practitioner under the *National Regulation Law,* the Accredited Person's registration:

(i) is suspended or cancelled; or

(ii) is made subject to a condition related to patient care and safety;

(d) the Accredited Person's registration under the law of another country or jurisdiction that provides for the registration of Health Practitioners is suspended or cancelled or made subject to a condition or another restriction because of the Accredited Person's conduct, professional performance or health;

(e) the Accredited Person has an Impairment;

(f) an Adjudication Body or a body with similar functions in any jurisdiction, makes an adverse finding, whether formal or informal, in relation an Accredited Person (including giving a caution or reprimand);

(g) the Accredited Person ceases to hold the Required Insurance;

(h) the Accredited Person materially breaches any Hospital Regulation;

(i) more than one breach of the Hospital Regulations (whether or not material) by the Accredited Person has occurred that, when these breaches are considered together, the Board is satisfied amount to conduct of a sufficiently serious nature to justify termination of Accreditation;

(j) the conduct of the Accredited Person materially and unreasonably hinders or may hinder the efficient operation and management of the Hospital;

(k) conduct of the Accredited Person is bringing, or may bring, the Hospital, the Hospital Licensee, or the University into disrepute;

(l) the behaviour or conduct of the Accredited Person is not consistent with the Objects or the stated values of the Hospital Licensee or the University (including the Faculty);

(m) the Accredited Person in relation to his or her Accreditation, provided to the Hospital Licensee information or made a representation that was materially incorrect, incomplete or misleading;

(n) the Accredited Person has been unable and unwilling to provide health services to patients at the Hospital for a period of at least 6 months;

(o) a review of the Accredited Person's Scope of Clinical Practice, in the case of an Accredited Medical Partitioner has been initiated under By-law 12 and the Medical Advisory Committee or the Independent Reviewer, as the case requires, has recommended termination of his or her Accreditation;

(p) the Accredited Person is convicted of, or is the subject of, a criminal finding for an offence which:

(i) if committed in New South Wales, is punishable by imprisonment; or

(ii) if committed elsewhere than in New South Wales, would have been an offence punishable by imprisonment if committed in New South Wales;

(q) the accreditation of the Accredited Person to practise or provide health services at a Health Facility or another facility at which health services is provided is withdrawn or restricted because of the Accredited Person's conduct, professional performance or health;

(r) the Accredited Person's billing privileges are withdrawn or restricted under the *Medicare Australia Act 1973* (Cth) because of the Accredited Person's conduct, professional performance or health;

(s) an authority of the Accredited Person under a law of a State or Territory of the Commonwealth of Australia to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines is cancelled or restricted;

(t) if the Accredited Person was an employee or contractor of the Hospital when Accredited, the Accredited Person ceases to be so;

(u) it is impractical for the Hospital Licensee to support the Accredited Person's Scope of Clinical Practice;

(v) the competency of the Accredited Person in speaking or otherwise communicating in English is not sufficient for the Accredited Person to provide health services at the Hospital;

(w) the Accredited Person has contravened a Special Condition of his or her Accreditation, in the case of an Accredited Medical Practitioner, or an undertaking given by the Accredited Person to the Hospital Licensee;

(x) the Accredited Person is for any reason:

(i) not a fit and proper person for Accreditation or otherwise not an appropriate person to be Accredited having regard to the Objects or the stated values of the Hospital Licensee; or

(ii) unable or unwilling to provide health services competently, safely and ethically to patients at the Hospital or elsewhere; or

(y) the Accredited Person does not otherwise meet a requirement of an Accreditation Standard.

University means Macquarie University, a statutory body corporate under the *Macquarie University Act 1989* (NSW).

Unsatisfactory Professional Conduct has the meaning given in the National Regulation Law[8].

Vice Chancellor means the vice-chancellor from time to time of the University.

Working Day means any day other than:

(a) a Saturday, a Sunday or a public holiday; or

(b) 27, 28, 29, 30 or 31 December,

in Sydney.

29.2 **Rules for interpreting this document**

29.2.1. In these By-laws, a reference to:

(a) an office holder includes any person deriving any function or power directly or indirectly by delegation or authorisation from that office holder;

(b) any person holding or occupying a particular office or position includes each person who from time to time occupies or is acting in that office or position;

(c) a person whose functions are assumed by another person because it ceases to exist, or otherwise includes the person who assumes all or substantially all of those functions and any related powers;

(d) a person includes an individual, a corporation, an unincorporated association, a body politic and the trustee of a trust;

(e) a minor is an individual who is under the age of 18 years;

(f) property includes moneys and information;

(g) a document means any record of information and includes:

(i) anything on which there is writing;

(ii) anything on which there are marks, figures, symbols or perforations having a meaning for persons qualified to interpret them;

[8] *National Regulation Law*, section 139B and 139C

(iii) anything from which sounds, images or writings can be reproduced with or without the aid of anything else; or

(iv) a map, plan, drawing or photograph;

(h) writing includes writing in digital form;

(i) a document or agreement, or a provision of a document or agreement, is to that document, agreement or provision as amended or novated;

(j) a word or expression that indicates a particular gender will be taken to indicate every other gender;

(k) the amendment of anything includes the variation or replacement of it;

(l) a word or expression in the singular form includes a reference to the word or expression in the plural form and vice versa;

(m) anything being published by the Hospital Licensee includes the Hospital Licensee causing it to appear on the Hospital Licensee's website;

(n) the National Regulation Law includes the corresponding legislation of another jurisdiction, if the context permits;

(o) Hospital Regulations means the present and future Hospital Regulations and includes consolidations and amendments of them;

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

(q) professional indemnity insurance means insurance against civil liability arising out of the provision of health services, and includes an agreement or arrangement for discretionary indemnity in respect of that liability;

(r) health services means the provision of medical, surgical and dental treatment and includes nursing and other clinical services and any related care, whether provided as public or private services;

(s) co-operating with a person includes assisting that person;

(t) carrying out an investigation includes the making of findings and recommendations by the investigator;

(u) a criminal finding means in respect of a criminal offence a finding or admission of guilt and includes:

(i) a finding that a criminal offence has been proved without proceeding to or recording a conviction; or

(ii) a finding that a criminal offence has been proved and the discharging of, or the making of an order releasing, the offender conditionally on entering into a good behaviour bond for a specified period or on other conditions decided by the court;

(v) a complaint includes anything arising out of the investigation of a complaint;

(w) a disciplinary body is to a person or body (including a professional standards committee) established under any statute or the constitution of any entity that has the power to discipline a Health Practitioner;

(x) a type of registration as a Health Practitioner is to that type of registration under the National Regulation Law and includes specialist registration, general registration provisional registration and limited registration.

29.2.2.

(a) In these By-laws the mention of anything after the word “include” or any derivative of it does not limit the nature or class of things included.

(b) If these By-laws define a word or expression, other parts of speech and grammatical forms of the word or expression have corresponding meanings.

(c) Headings in these By-laws are not part of it and must be ignored in interpreting it.

(d) Notes in these By-laws are not part of it and must be ignored in interpreting it.

(e) A reference in a schedule to a clause is to a clause in that schedule unless the context indicates otherwise.

(f) The schedules to these By-laws are part of them and binding.

(g)

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

(ii) If it is not possible to read down a provision as required by By-law 29.2.2(g)(i), the provision will be severed from these By-laws and the remaining provisions will have continuing operation.

29.2.3. In the interpretation of a provision of these By-laws, a construction that would promote the Objects must be preferred to a construction that would not promote them.

29.2.4. Each ground for termination or suspension of Accreditation is separate and independent and is not limited by reference to any other specified ground.

SCHEDULE 1

General conditions

1. Compliance with General Conditions and Special Conditions An Accredited Person must comply with the provisions of this Schedule 1.

2. Compliance and Conduct

2.1. An Accredited Person must comply with:

(a) all applicable laws, including laws relating to the registration and conduct of Health Practitioners, private health facilities and the provision of professional services which are eligible for Medicare;

(b) the Hospital Regulations;

(c) generally accepted professional and ethical standards applicable to the Accredited Person's profession and specialty including by not charging fees which are, in the circumstances, manifestly excessive; and

(d) any Special Conditions applicable to that Accredited Person.

2.2. An Accredited Person must comply with the reasonable requirements and directions of the Hospital Licensee relating to personal conduct in the Hospital and management of the Hospital.

2.3. An Accredited Person must comply with the stated requirements of the Hospital Licensee relating to the provision of health services in the Hospital (whether or not those requirements are set out in the Hospital Regulations).

2.4. An Accredited Person must act in a manner consistent with the Objects and the stated values of the Hospital Licensee.

2.5. An Accredited Person must:

(a) not aid, facilitate or cause the provision of Health Care at the Hospital by persons who are not Accredited Persons (Accredited); and

(b) comply with the Hospital Regulations relating to:

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

(ii) the presence of students and Medical Observers in clinical areas of the Hospital.

(c) as soon as becoming aware of a Suspension Event or Termination Event in relation to another Accredited Person, to immediately advise the Chief Executive Officer.

2.6. An Accredited Person must comply with the reasonable requirements of the Hospital Licensee relating to access to the Hospital facilities including the scheduling of surgical lists.

3. **Insurance**

3.1. An Accredited Person must take out and maintain insurance:

(a) in accordance with any applicable registration standards determined under the National Regulation Law;

(b) which satisfies any other requirement of the Chief Executive Officer and the Board (including limits of indemnity);

(c) which insures the Accredited Person in respect of all of his or her Scope of Clinical Practice (in the case of a Medical Practitioner) and areas of practice; and

(d) which does not have material exclusions, relevant to the Accredited Person's Scope of Clinical Practice (in the case of a Medical Practitioner) or areas of practice or excesses or deductions which are unacceptable to the Chief Executive Officer.

3.2. An Accredited Person must not treat any patient at the Hospital unless he or she is covered by the Required Insurance.

3.3. An Accredited Person must not falsely represent to any person that the Accredited Person is covered by the Required Insurance.

4. Quality Assurance and Continuing Professional Development

4.1. An Accredited Medical Practitioner must:

(a) participate and co-operate in peer review, clinical review, clinical audit and quality assurance activities established by the Hospital Licensee;

(b) participate and co-operate in the collection, review and reporting of information relating to the operation of the Hospital and the medical cases treated at the Hospital; and

(c) co-operate with the Hospital Licensee in relation to the maintenance of accreditation of the Hospital.

4.2. An Accredited Health Practitioner must participate in continuing professional development:

(a) in accordance with any applicable registration standards determined under the National Regulation Law;

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

(c) as otherwise required by the Chief Executive Officer, the Medical Advisory Committee or his or her Clinical Program Head.

5. Activity

5.1. An Accredited Medical Practitioner must maintain a regular level of activity at the Hospital.

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

5.3. In this clause 5, the criteria for determining what a “regular level of activity” is may be determined by the Chief Executive Officer (after consultation with the relevant Clinical Program Head).

5.4. In the absence such a determination, a "regular level of activity" means:

(a) for an anaesthetist and proceduralist, a regular and utilised operating list each month;

(b) for a physician, or non-proceduralist, an average of at least one Hospital admission each month;

(c) for any other Accredited Medical Practitioner, attending on or reporting in relation to patients at the Hospital on a regular basis each month; and

(d) if relevant and applicable to the Accredited Medical Practitioner's specialty or clinical service type:

(i) regular participation on a Hospital Licensee administered roster for the day-to-day delivery of Health Care; and

(ii) regular teaching or other approved educational activity or research at the Hospital.

6. Disclosure

6.1. An Accredited Person must on or about a date specified by the Hospital Licensee in each year, or otherwise on request, provide to the Chief Executive Officer, in a form required by the Chief Executive Officer:

(a) evidence satisfactory to the Chief Executive Officer of the Accredited Person's registration as a Health Practitioner under the National Regulation Law (if applicable to the Accredited Person);

(b) evidence satisfactory to the Chief Executive Officer of the Accredited Person's registration with or membership of their professional association or body;

(c) evidence satisfactory to the Chief Executive Officer that the Accredited Person is covered by the Required Insurance;

(d) evidence satisfactory to the Chief Executive Officer that the Accredited Person has satisfied the requirements of these By-laws with respect to continuing professional development; and

(e) a declaration in form and content satisfactory to the Chief Executive Officer relating to any matters that the Chief Executive Officer is satisfied are relevant to the Accredited Person's Accreditation or, in the case of an Accredited Medical Practitioner, Scope of Clinical Practice.

6.2. An Accredited Person must promptly notify the Chief Executive Officer in writing and provide full details of:

(a) any Termination Event or Suspension Event that occurs;

(b) any complaint made against the Accredited Health Practitioner pursuant to Part 8 of the National Regulation Law;

(c) any complaint made against an Accredited Person to a Health Complaints Entity;

(d) any adverse finding, whether formal or informal, in relation to an Accredited Person (including a caution or reprimand) by an Adjudication Body or similar body in another jurisdiction;

(e) any mandatory notification that is made pursuant to Part 8 of the National Regulation Law in respect of the Accredited Health Practitioner;

(f) any Impairment or notification of Impairment in respect of the Accredited Health Practitioner that is made pursuant to Part 8 of the National Regulation Law;

(g) any performance assessment undertaken or proposed in respect of the Accredited Health Practitioner, pursuant to Part 8 of the National Regulation Law;

(h) any investigation or inquiry by a regulatory, disciplinary or investigative agency or a professional body in any jurisdiction about the Accredited Person;

(i) if the Accredited Person ceases to be covered by the Required Insurance;

(j) any fact or circumstance which entitles the Accredited Person to make a claim under the Required Insurance;

(k) any fact or circumstance that would cause any statement, information or representation provided in relation to an application for Accreditation or renewal of Accreditation to be or become incorrect, incomplete or otherwise misleading;

(l) the suspension, cancellation, or variation (including the imposition of conditions) of an approval given to the Accredited Person by the operator of a Health Facility other than the Hospital to admit or treat patients or otherwise provide health services at that Health Facility;

(m) the investigation of a complaint against or regarding the conduct of the Accredited Person by the operator of another Health Facility in relation to anything done or omitted by the Accredited Person in relation to that Health Facility;

(n) any litigation, arbitration, administrative or disciplinary proceedings which are commenced or threatened against the Accredited Person which relate to the Accredited Person's behaviour as a Health Practitioner or Health Care Worker;

(o) any other fact or circumstance known to the Accredited Person from time to time and which a reasonable person would regard as relevant to the assessment by the Hospital Licensee of the suitability of the Accredited Person to be Accredited or to continue to be Accredited including anything:

(i) relevant to the Accredited Person's Accreditation or, in the case of an Accredited Medical Practitioner, Scope of Clinical Practice; or

(ii) relevant to the Accredited Person's ability to provide health services competently, safely and effectively; and

(p) any fact or circumstance in relation to any of the above matters in respect of another Accredited Person.

6.3. An Accredited Person must promptly provide to the Chief Executive Officer any statement, information or documentation which is provided to any specialist college, professional body or regulatory body in Australia or elsewhere (including the Health Care Complaints Commission).

6.4. A Health Care Worker must comply with the Code of Conduct made for under Schedule 3 of the *Public Health Regulation 2012*.

7. Cooperation with investigations and other processes

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

(a) the Accredited Person's Accreditation or, in the case of an Accredited Medical Practitioner, their Scope of Clinical Practice;

(b) the Accredited Person's suitability to practice or otherwise provide health services at the Hospital; or

(c) the behaviour of the Accredited Person.

7.2. An Accredited Person must cooperate with any review, investigation, enquiry or process undertaken by or on behalf of the Hospital Licensee relating to the provision of health services at the Hospital including any act or omission of another Accredited Person or any other Health Services Provider or any staff of the Hospital Licensee or any Accredited Person.

7.3. An Accredited Person's obligation to co-operate under this clause 7 includes:

(a) providing access to and use of any premises, property, computer or other facilities owned, controlled or used by that Accredited Person or where records or information relating to that Accredited Person are kept;

(b) verifying information, evidence or answers as requested;

(c) attending assessments, meetings, hearings and other proceedings as requested;

(d) not preventing, interfering with or hindering:

(i) any investigation, assessment, meeting, hearing or other proceeding relating to a complaint;

(ii) any person's participation in any such thing; or

(iii) any person's compliance with any sanction or requirement imposed in respect of any complaint or failure to comply with any Hospital Regulation; and

(e) not improperly influencing any person.

7.4. An Accredited Person is not obliged to provide information to any person pursuant to these By-laws if he or she satisfies the Hospital Licensee that the Accredited Person is legally prohibited from providing it.

8. Records

8.1. An Accredited Person must make complete, accurate and legible medical records:

(a) as soon as practicable after the occurrence of the matter to be recorded;

(b) in the form required by the Hospital Licensee and complying with the Hospital Licensee's medical records policy;

(c) in accordance with the requirements of any applicable law;

(d) in accordance with the requirements of the accreditation agency for the Hospital; and

(e) in a way which enables the Hospital Licensee to collect revenue from the operation of the Hospital in a timely fashion.

8.2. An Accredited Person must comply with the Hospital Licensee's lawful requirements relating to:

(a) obtaining and documenting patient consent to the provision of health services;

(b) admission and discharge of patients;

(c) written confirmation of verbal directions for the provision of health services;

(d) requests and orders for diagnostic tests; and

(e) prescriptions and orders for drugs and therapeutic goods.

8.3. An Accredited Person must co-operate in the maintenance of medical records in electronic form by the Hospital Licensee.

8.4. An Accredited Person must only access medical records of the Hospital:

(a) to the extent necessary for the provision of health services to patients at the Hospital;

(b) in accordance with Privacy Laws; and

(c) in accordance with any applicable requirements of the Hospital Licensee in relation to access to records for the purpose of medical or other research.

9. Hospital Administration

9.1. An Accredited Person must give notice of any un-scheduled absence or intention to postpone or cancel a procedural list or session which has been booked for the Accredited Person, in accordance with the requirements of the Hospital Licensee.

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

9.3. An Accredited Medical Practitioner, must ensure he or she is available for emergency calls to the Accredited Medical Practitioner's patients (or has appointed an appropriately qualified Accredited Medical Practitioner for this purpose) at the Hospital, unless exempted by the Chief Executive Officer.

9.4. An Accredited Medical Practitioner, must attend and participate in meetings of the Clinical Programs to which he or she belongs unless the Clinical Program Head has given consent not to attend or participate or the Accredited Medical Practitioner otherwise has a reasonable excuse not to attend or participate.

9.5. An Accredited Person must not purport to represent in any way (including by use of letterhead), the Board, the Hospital, the University or the Faculty except with the prior, express written permission of the Board, Chief Executive Officer, Vice-Chancellor or executive dean of the Faculty, as the case requires.

10. Teaching and Training

An Accredited Person must facilitate, promote and participate in the teaching and training of Hospital personnel, junior medical staff, clinical trainees and medical students to the extent reasonably required by the Hospital Licensee.

11. Collusion - prohibited

A person must not:

(a) cause, incite, instruct, aid or conspire with or assist another person to contravene any Hospital Regulation or conceal a contravention or otherwise be party to a contravention or concealment of a contravention of Hospital Regulations; or

(b) fail to promptly disclose when requested the identity or whereabouts of any person who is alleged to have breached any Hospital Regulation.

12. Use of Hospital name and logos

An Accredited Person must not use the name, emblem, trademarks or logos of the University or any of its controlled entities except with the written consent of the Board and in accordance with any conditions subject to which the consent is given.

SCHEDULE 2

Committee Matters

1. **General Application**

   The provisions of this Schedule 2 will apply to every committee contemplated by these By-laws subject to any contrary provision of these By-laws.

2. **Committee Decisions**

   2.1. A resolution of a Relevant Committee must be passed by a majority of the votes cast by members of it entitled to vote on the resolution.

   2.2. The chair of a Relevant Committee has the casting vote, if necessary, in addition to any vote he or she has in their capacity as a member.

   2.3.

   (a) At a meeting of members of a Relevant Committee on a show of hands, on a poll or otherwise each member has one vote.

   (b) A resolution put to the vote at a meeting of a Relevant Committee must be decided on a show of hands unless a poll is demanded.

   (c) On a show of hands, a declaration by the chair is conclusive evidence of the result provided that the declaration reflects the show of hands.

   (d) A poll demanded on a matter other than the election of a chair or the question of an adjournment must be taken when and in the manner the chair directs.

   (e) A poll on the election of a chair or on the question of an adjournment must be taken immediately.

   2.4. A challenge to a right to vote at a meeting of a Relevant Committee:

   (a) may only be made at the meeting; and

   (b) must be determined by the chair, whose decision is final.

3. **Chair**

   3.1. The chair of a Relevant Committee will be a person appointed by the Board from the members of the Relevant Committee.

   3.2. If the Board has not appointed a chair of the Relevant Committee:

   (a) the Relevant Committee may appoint a member to chair their meetings; and

   (b) the Relevant Committee may determine the period for which the member is to be the chair.

   3.3. The members of a Relevant Committee must elect a member present to preside at a meeting, or part of it, if:

   (a) a member has not already been appointed to chair the meetings; and

   (b) a previously appointed chair is not available or declines to act, for the meeting or that part of the meeting.

4. **Procedure**

The chair of the Relevant Committee may determine any question of procedure for the Relevant Committee.

5. **Termination and Replacement of Member**

5.1. A person ceases to be a member of a Relevant Committee if that person:

(a) dies;

(b) in the case of the Medical Advisory Committee or the CIA Committee, ceases to be an Accredited Medical Practitioner;

(c) resigns office by notice in writing given to the Chief Executive Officer;

(d) is removed from office under these By-laws;

(e) has an Impairment;

(f) is absent without the consent of the Relevant Committee from 3 consecutive meetings of the committee; or

(g) is found guilty in Australia or elsewhere of an offence involving fraud or dishonesty for which the maximum penalty on conviction is imprisonment for at least 3 months.

5.2. An appointor of an appointed member of a Relevant Committee may vary or revoke their appointment of that member and appoint a replacement if their appointee ceases to be a member for any reason.

5.3. Subject to these By-laws, a member of a Relevant Committee holds office as follows:

(a) in the case of a member who is a member by virtue of their position or office while the member holds that position or office;

(b) in the case of a Board appointed member, for such term (not exceeding 3 years) as may be specified in the member's instrument of appointment.

6. **Alternate**

6.1. With the approval of their appointor and the Board, a member of a Relevant Committee may appoint an alternate to exercise some or all of that person's powers for a specified period.

6.2. If the appointing member requests the Relevant Committee to give an alternate notice of meetings, it must do so.

6.3. When an alternate exercises the member's powers, the exercise of those powers is just as effective as if the powers were exercised by the member.

6.4. The appointing member may terminate the alternate's appointment at any time.

6.5. An appointment or its termination must be in writing.

6.6. An alternate for a member of the Medical Advisory Committee or a member of the CIA Committee who is a Medical Practitioner must be an Accredited Medical Practitioner and be otherwise eligible for membership of that committee.

6.7. The Chief Executive Officer must be promptly given notice by the appointor of the appointment and termination of appointment of an alternate.

7. **Calling meeting**

7.1. A meeting of a Relevant Committee may be called by the chair or the Chief Executive Officer giving notice to every member of it.

7.2.

(a) Subject to any By-law to the contrary, at least 5 Working Days' notice of a meeting of the Relevant Committee must be given.

(b) A notice of a meeting must specify the place and time of meeting.

(c) In an emergency, as much notice as is practicable in the circumstances must be given.

(d) A person who has appointed an alternate member may require that the notice be also sent to the alternate member.

7.3.

(a) Notice of a meeting must specify the general nature of the business to be transacted at the meeting.

(b) No business other than that business is to be transacted at the meeting, except business which the committee members present at the meeting unanimously agree to treat as urgent business.

8. **When notice is given electronically**

8.1. A notice of meeting sent by post is taken to be given three Working Days after it is posted.

8.2. A notice of meeting sent by electronic means, is taken to be given on the Working Day after it is sent.

9. **Quorum**

9.1. The quorum of a Relevant Committee is:

(a) where there is an odd number of members of a Relevant Committee, a majority of the members; or

(b) where there is an even number of members of the Relevant Committee, one half of the number of the members plus one.

9.2. A quorum must be present for the entire meeting.

9.3. A person must not, either alone or with other persons, leave or refuse to attend a meeting of a Relevant Committee so as to ensure that a quorum is not present at the meeting.

9.4. If a person withdraws from a meeting so as to remove the quorum, the meeting may proceed as if a quorum is present and any decision of the Relevant Committee will not be invalid merely because of the absence of a quorum for this reason.

9.5. If a meeting of a Relevant Committee that does not have a quorum present within thirty minutes after the time for the meeting set out in the notice of meeting, then that meeting is adjourned to the date, time and place the Chair specifies.

9.6. If the Chair does not specify one or more of those things, the meeting is adjourned to:

(a) if the date is not specified—the same day in the next week;

(b) if the time is not specified—the same time; and

(c) if the place is not specified—the same place.

9.7. If no quorum is present at the resumed meeting within thirty minutes after the time for the meeting, the meeting is dissolved.

10. **Adjournment**

10.1. The chair may adjourn a meeting of a Relevant Committee if and when he or she thinks appropriate.

10.2. When a meeting is adjourned, a new notice of the resumed meeting must be given if the meeting is adjourned for one month or more.

10.3. A resolution passed at a meeting resumed after an adjournment is passed on the day it was passed not upon the day of the adjourned meeting.

10.4. Only unfinished business is to be transacted at a meeting resumed after an adjournment.

11. **Use of Technology**

11.1. A meeting of a Relevant Committee may be called or held using any technology that permits each participant to communicate with other participants.

11.2. If the members are not all in attendance at one place and are holding an Electronic Meeting:

(a) the members are, for the purpose of every provision of these By-laws concerning meetings of the Relevant Committee, taken to be assembled together at a meeting and to be present at that meeting; and

(b) all proceedings of those members conducted in that manner are as valid and effective as if conducted at a meeting at which all of them were present.

11.3. A person participating in a meeting using any technology must not allow the proceedings to be overheard or recorded.

11.4. Papers may be circulated among and provided to members of a Relevant Committee by email or other transmission of the information in those papers.

12. **Resolutions without meetings**

12.1. A Relevant Committee may pass a resolution without a meeting of its members being held if:

(a) all of the papers are circulated among all of the members of the Relevant Committee; and

(b) all of the members entitled to vote on the resolution sign a document or send an email containing a statement that they are in favour of the resolution set out in the document.

12.2. The resolution is passed when the last member signs the document or sends the email, as the case requires.

13. **Decisions not affected by certain matters**

An act or decision of a Relevant Committee is not invalid only because:

(a) of a defect or irregularity in the appointment of a member or acting member;

(b) of a vacancy in its membership; or

(c) the reason for the appointment of an acting member has ceased to exist.

14. Minutes

14.1. The Chair must ensure that minutes of all meetings of the Relevant Committee are prepared.

14.2. Minutes must be distributed to all those entitled to attend meetings of the Relevant Committee prior to the next meeting.

14.3. Except for an emergency meeting of the Relevant Committee, no business may be considered at a meeting of the Relevant Committee until the minutes of the previous meeting have been confirmed or otherwise dealt with.

14.4. No discussion of the minutes is permitted except as to their accuracy.

14.5. Minutes of a meeting must be confirmed by resolution of the Relevant Committee and signed by the chair, at the next meeting.

14.6. Minutes so confirmed and signed will be taken as evidence of the proceedings of the relevant meeting.

15. Duties of Committee Members

15.1. A member of a Relevant Committee must:

(a) carry out his or her functions:

(i) in good faith;

(ii) to further the Objects;

(iii) honestly; and

(iv) otherwise for a proper purpose.

(b) exercise their powers and discharge their duties with the degree of care, skill and diligence that a reasonable person would exercise if they were a member of the Relevant Committee;

(c) not profit, directly or indirectly, from his or her position;

(d) not make improper use of his or her position or information acquired because of his or her position, to:

(i) gain, directly or indirectly, an advantage for the member or any other person; or

(ii) cause detriment to any person.

15.2. The Board may remove a member of a Relevant Committee from office for breach of a duty set out in this clause 15, by written notice to the member.

15.3. A member of a Relevant Committee is not entitled to receive remuneration for any services provided in that capacity.

16. **Conflicts of Interest**

16.1. A member of any Relevant Committee or a person authorised to attend any meeting of a Relevant Committee, who has a Conflict of Interest:

(a) in a matter that has been considered or is about to be considered at a meeting of the Relevant Committee;

(b) in a thing done or proposed to be done by the Hospital Licensee, must:

(i) as soon as possible, notify the other members of the Relevant Committee of the existence and the nature of the Conflict of interest; and

(ii) not participate in the discussion of or vote on any resolution relating to the matter or thing except, after having disclosed the Conflict of Interest, with the consent of the chair of the Relevant Committee.

16.2.

(a) A disclosure by a person to the Relevant Committee that the person:

(i) is a member, partner, employee or contractor of a specified company, person or body; or

(ii) has some other specified interest relating to a specified company, person or body,

may be given as a standing notice.

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

16.3. The chair of the Relevant Committee must ensure that particulars of any disclosure made under clause 16.1 or clause 16.2 are recorded in the minutes of the Relevant Committee.

17. **Sub-committees**

This Schedule 2 applies (with necessary adaptations) to each sub-committee of a Relevant Committee and to the members of each sub-committee in the same way as it applies to the Relevant Committee and the members of the Relevant Committee as if a reference to a Relevant Committee is to the sub-committee and a reference to the members of a Relevant Committee are to the members of the sub-committee.