Perth Clinic By-Laws

February 2018

perth Clinic

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1. INTRODUCTION

1.1 Perth Clinic

Perth Clinic (***Clinic***) is an independent hospital providing mental health services. The Clinic was established in July 1996 and is located at 29 Havelock Street, West Perth.

1.2 Objectives of the Clinic

The objectives of the Clinic are to:

(a) be at the forefront of mental health care for the privately insured patients of Perth and regional areas;

(b) provide excellent clinical care through service and commitment to patients, their families and referring doctors;

(c) provide a multi-disciplinary service with emphasis on the provision of a range of cost effective brief therapies;

(d) achieve excellence by focusing on quality management in order to offer a service to patients which is proactive, competent and personalised;

(e) pursue efficiency for the benefit of patients through day hospital therapies that enable reduced inpatient stays;

(f) provide opportunities and encouragement for staff of the Clinic to continue to develop both personally and professionally;

(g) maintain a comfortable and aesthetically pleasing environment; and

(h) be a centre for education of health professionals and the community.

1.3 Purpose of this document

This document sets out the terms and conditions on which Medical Practitioners are Accredited to admit patients or to care for, treat and render specific clinical, diagnostic, therapeutic or medical services to patients at the Clinic in accordance with the approved Scope of Clinical Practice for the Accredited Practitioner.

This document forms part of the governance framework for the Clinic, defining and allocating the roles and responsibilities for Accredited Practitioners in relation to safety and quality for the Clinic's patients.

1.4 Annexure is incorporated in these By-Laws

The annexure to these By-laws are integrated with the By-Laws and are intended to ensure consistent application of the processes for Accreditation.

1.5 Overview of Application process

(a) In accordance with the terms of these By-Laws:

(i) the Medical Advisory Committee considers Applications and recommends to the Executive Committee whether or not a Medical Practitioner should be granted Accreditation, the appropriate Scope of Clinical Practice, and any special conditions which should be imposed on Accreditation; and

(ii) the Executive Committee determines whether a Medical Practitioner will be granted Accreditation, the appropriate Scope of Clinical Practice, and any special conditions which should be imposed on Accreditation.

(b) When the Medical Advisory Committee or the Executive Committee is considering a matter regarding Accreditation, each is required to do so in a closed session with only members present.

2. MISSION GOALS AND VALUES

2.1 Mission Statement

"Empowering you on the journey to mental health recovery."

(a) We believe in innovation and creativity in providing services of excellence.

(b) We believe in the encouragement of professional and personal development.

(c) We believe in encouraging accomplishment and contribution.

(d) We work as a team to be the best in all we do.

(e) We create an atmosphere of care, trust, concern and respect for our patients and each other.

(f) We adhere to the highest ethics and a code of honour and integrity.

(g) We will behave in a fair and open way.

(h) We believe that quality processes will produce quality results.

(i) We believe that solutions should be cost effective and add value.

2.2 Goals

(a) We will pursue our vision through focussed growth based on our innovative treatment models and strong position in mental health care and treatment.

(b) We will pursue our innovative approaches in providing quality and value with determination and vigour.

(c) We will strive for quality in all areas of what we do in our programmes, treatment systems technology and information systems, financial results, management and our relationship with patients, staff, shareholders, stakeholders, referrers, insurers and psychiatrists.

2.3 Values

In pursuing what we do we will aspire to live by the following values:

(a) Trust;

(b) Respect;

(c) Integrity; and

(d) Empathy.

3. DEFINITIONS

In these By-Laws, unless the contrary intention appears, the following expressions shall have the following meanings:

Accredited Practitioner means a Medical Practitioner who has been granted Accreditation.

Accreditation means the granting of Visiting Rights or Privileges to a Medical Practitioner in respect of particular areas of practice, or for particular types of treatment (as the case requires), within a defined Scope of Clinical Practice, on conditions set out in these By-Laws and any other special conditions which the Clinic (acting through either the Executive Committee or the Chief Executive Officer) may impose from time to time.

Adequate Professional Indemnity Insurance means insurance, including run off/tail insurance, to cover all potential liability of the Accredited Practitioner, that is with a reputable insurance company acceptable to the Clinic, and is in an amount and on terms that the Clinic considers in its absolute discretion to be sufficient. The insurance must be adequate for Scope of Clinical Practice and level of activity.

Appeal Panel is defined in By-Law 8.10(e).

Appellant is defined in By-Law 8.10(d).

Application means an application by a Medical Practitioner for the grant or renewal of Visiting Rights and Privileges on the prescribed form, as annexed to these By-Laws.

Board means the board of directors of Perth Clinic.

Business Day means any day which is not a Saturday, Sunday or public holiday in Western Australia.

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

Chief Executive Officer means the person appointed by the Board to act in that position.

Clinic is defined in By-law 1.1.

Clinical Practice means the professional activity undertaken by Accredited Practitioners for the purposes of investigating patient symptoms and preventing and/or managing illness, together with associated professional activities related to clinical care.

Competence means, in respect of a person who applies or reapplies for Accreditation, that the person is possessed of the necessary aptitude in the application of knowledge and skills in interpersonal relationships, decision making and Performance necessary for the Scope of Clinical Practice for which the person has applied and has the demonstrated ability to provide health services at an expected level of safety and quality.

Confidential Information means information concerning the Clinic or a patient which an Accredited Practitioner knows, or ought reasonably to know, is confidential.

Credentials means, in respect of a person who applies or reapplies for Accreditation, the qualifications, professional training, clinical experience and training and experience in leadership, research, education, communication and teamwork that contribute to the person's Competence, Performance and professional suitability to provide safe, high quality health care services. The applicant's history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal regard are relevant to their Credentials.

Current Fitness is the current fitness required of a person who applies, reapplies or holds Accreditation to carry out the Scope of Clinical Practice sought or currently held. A person is not to be considered as having current fitness if that person suffers from any physical or mental impairment, disability, condition or disorder (including habitual drunkenness or addiction to deleterious drugs) which detrimentally affects or is likely to detrimentally affect the person's physical or mental capacity to practice.

Executive Committee means the committee appointed by the Board from time to time to supervise the management of the Clinic.

Long Term Accreditation is defined in By-Law 5.3(a).

Medical Advisory Committee means the committee whose members are elected by the Accredited Practitioners and known as such.

Medical Practitioner means a person who has a current unconditional registration by the Medical Board of Australia.

Organisational Capability means the Clinic's ability to provide the facilities, services and clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational Capability will be determined by consideration of the availability, limitations and/or restrictions of the services, staffing, facilities, equipment, and support services required. The approved level of service capability may be specified on the licence to operate.

Organisational Need means the extent to which the Clinic is required to provide a specific clinical service, procedure or other intervention in order to provide a balanced mix of safe, high quality health care services that meet consumer and community needs and aspirations.

Performance means the extent to which an Accredited Practitioner provides health care services in a manner which is consistent with known good Clinical Practice and results in expected patient benefits.

Privileges means the rights granted to a Medical Practitioner by the Executive Committee to render specific clinical, diagnostic, therapeutic or medical services at the Clinic.

Rules and Regulations means rules and regulations prescribed by the Executive Committee in respect of the Clinic from time to time.

Scope of Clinical Practice means the extent of an individual Accredited Practitioner's permitted Clinical Practice within the Clinic based upon the individual's Credentials, Competence, Performance and professional suitability, and the Organisational Capability and Organisational Need of the Clinic to support the Accredited Practitioner's scope of clinical practice.

Temporary Accreditation is defined in By-Law 5.3(b).

Visiting Rights means the rights granted to a Medical Practitioner by the Executive Committee to admit a patient to the Clinic, or to treat a patient admitted by another Medical Practitioner at the Clinic.

4. INTERPRETATION

Headings are for convenience only and do not affect interpretation. The following rules apply unless the context requires otherwise.

(a) The singular includes the plural and vice versa.

(b) Any gender includes the other genders.

(c) If a word or phrase is defined, its other grammatical forms have a corresponding meaning.

(d) A reference to a person, corporation, trust, partnership, unincorporated body or other entity includes any of them.

(e) A reference to a By-Law or annexure is a reference to a By-Law of or an annexure to these By-Laws.

(f) A reference to the By-Laws, Rules and Regulations, a policy, procedure, agreement or document is to the By-Laws, Rules and Regulations, a policy, procedure, agreement or document as amended, varied, supplemented, novated or replaced, except to the extent prohibited by these By-Laws or that other agreement or document.

(g) A reference to legislation or to a provision of legislation includes a modification or re-enactment of it, a legislative provision substituted for it and a regulation or statutory instrument issued under it.

(h) A reference to conduct includes an omission, statement and undertaking, whether or not in writing.

(i) A reference to an ***agreement*** includes any undertaking, deed, agreement and legally enforceable arrangement, whether or not in writing, and a reference to a document includes an agreement (as so defined) in writing and any certificate, notice, instrument and document of any kind.

(j) A reference to ***dollars*** and ***$*** is to Australian currency.

(k) A reference to ***writing*** includes any method of representing or reproducing words, figures, drawings or symbols in a visible form but excludes any communication using electronic mail.

(l) The meaning of general words is not limited by specific examples introduced by ***including***, or ***for example***, or similar expressions.

5. ACCREDITATION OF PRACTITIONERS

5.1 Only Accredited Practitioners may exercise Visiting Rights and Privileges

Except as expressly stated otherwise in By-Law 6.1(e), only Accredited Practitioners may exercise Visiting Rights and Privileges at the Clinic.

5.2 Obtaining Visiting Rights or Privileges

(a) A Medical Practitioner may apply for Accreditation by completing the prescribed application form (as annexed to these By-Laws) and submitting the form to the Chief Executive Officer.

(b) The Chief Executive Officer must promptly forward the Application to the Medical Advisory Committee.

5.3 Term of appointment

Applicants may apply for a term of Accreditation:

(a) up to three years (***Long Term Accreditation***); or

(b) thirty days (***Temporary Accreditation***).

5.4 Categories and conditions of Accreditation

(a) Applicants may apply for Visiting Rights or Privileges or both in any of the areas of practice specified on the Application. This will include admission and non-admission rights.

(b) Scope of Clinical Practice in relation to electroconvulsive therapy treatment must be specifically applied for and approved.

(c) The Executive Committee, or in the case of Temporary Accreditation, the Chief Executive Officer, may impose special conditions on Accredited Practitioners in addition to the common conditions imposed on Accredited Practitioners set out in By-Law 6.

5.5 Accreditation is confidential

(a) Any information concerning a Medical Practitioner's Accreditation is Confidential Information, including information concerning the Clinic's refusal to grant Accreditation or varying, suspending or terminating Accreditation.

(b) Except for the purpose of obtaining legal advice or under compulsion of law, a Medical Practitioner must not disclose information concerning the Medical Practitioner's Accreditation to any person who is not involved in the Accreditation process under these By-Laws.

5.6 Accreditation explanation

(a) It is a condition of accepting Accreditation, and of ongoing Accreditation, that Accredited Practitioners understand and agree that:

(i) these By-Laws are the full extent of processes and procedures available to Accredited Practitioners with respect to all matters relating to and impacting upon Accreditation;

(ii) no additional procedural fairness or natural justice principles will be incorporated or implied, other than processes and procedures that have been explicitly set out in these By-Laws;

(iii) the mere fact of granting of Accreditation does not give rise to the formation of a contract or an employment relationship with the Clinic;

(iv) the granting of Accreditation establishes only that the Accredited Practitioner is a person able to provide services at the Clinic, as well as the obligations and expectations with respect to the Accredited Practitioner while providing services at the Clinic for the period of Accreditation;

(v) the granting of Accreditation creates no rights or legitimate expectation with respect to the Clinic or its resources; and

(vi) while the Clinic and Board will generally conduct itself in accordance with the By-Laws, the Clinic and Board are not bound to do so and there are no legal consequences for not doing so.

6. CONDITIONS OF ACCREDITATION

6.1 Admitting, treating and discharging patients

(a) An Accredited Practitioner may seek to admit a patient to the Clinic, however, the Clinic may, in its sole and absolute discretion refuse the admission of any patient as the grant of Accreditation contains no conferral of, or a general expectation of, or a right of access to the Clinic.

(b) An Accredited Practitioner who admits a patient is responsible for that patient.

(c) An Accredited Practitioner must conduct a physical examination of the patient, and with respect to the conduct of a physical examination, the Accredited Practitioner must:

(i) physically attend upon his or her patient in order to commence the conduct of a physical examination as soon as practicable after the patient is admitted or received at the Clinic, with this first attendance to be no later than 12 hours from the time the patient is admitted by or received at the Clinic;

(ii) continue to physically attend upon the patient at reasonable intervals after the initial attendance until the first of the following occurs;

(A) the patient is able to be examined by the admitting Accredited Practitioner or an Accredited General Practitioner in order to assess the patient's physical condition;

(B) the patient refuses consent to an examination and the Accredited Practitioner documents the reasons for refusal/rationale for not performing the physical examination in the patient health record;

(C) the patient's authorised person (where the patient does not have capacity) refuses to consent to the examination of the patient; or

(D) the patient is discharged or otherwise leaves.

(iii) following the physical examination of a patient, as soon as practicable, record in the Clinic medical record:

(A) the Accredited Practitioner's name and qualifications;

(B) the date and time the examination was conducted; and

(C) the results of all examinations undertaken.

(d) An Accredited Practitioner must:

(i) visit his or her patient with reasonable frequency having regard to the patient's mental illness and physical condition. As general guidance, it is the expectation that the higher the level of risk and the higher the level of medical input required, the more frequently the Accredited Practitioner is expected to attend in person upon the patient, and the lower the level of risk and the lower the level of medical input required, the less frequently the Accredited Practitioner is required to attend in person upon the patient, but in any event, a minimum of 2 attendances per week is expected;

(ii) respond quickly and appropriately to telephone calls from nursing staff;

(iii) provide telephone contact details to nursing staff; and

(iv) be contactable by telephone at all times.

(e) If an Accredited Practitioner agrees to deputise for another Accredited Practitioner, the deputy Accredited Practitioner must also be contactable by telephone at all times.

(f) An Accredited Practitioner may request or engage a Medical Practitioner who is not accredited to review a patient and provide an opinion on a single occasion or intermittent occasions but must not permit the other Medical Practitioner to prescribe medication, treatment or diagnostic tests for the patient.

(g) Only the Accredited Practitioner responsible for the patient may authorise the patient's discharge from the Clinic.

(h) Shall assist with preparation, communication with patients and addressing non-compliance with respect to patient management plans (the plans may include behavioural expectations and compliance with Clinic policies, procedures and treatment plans), and if appropriate in the circumstances shall assist with facilitating discharge of patients from the Clinic for non-compliance with management plans.

6.2 Transferring patient care

(a) If an Accredited Practitioner wishes to transfer the care of a patient, he or she must:

(i) arrange for another Accredited Practitioner to accept responsibility for the patient's care; and

(ii) notify the Clinic in writing of the arrangements.

(b) The notice in By-Law 6.2(a)(ii) must include:

(i) the name of the Accredited Practitioner who is accepting responsibility for the patient;

(ii) the date and time at which the transfer of responsibility will occur; and

(iii) the signatures of the Accredited Practitioner transferring responsibility and the Accredited Practitioner who is accepting responsibility for the patient.

(c) For the avoidance of doubt, the Clinic will consider the admitting Accredited Practitioner responsible for the patient until it receives written notice pursuant to By-Law 6.2(a)(ii).

6.3 Medical records

(a) Every Accredited Practitioner must keep a Clinic medical record in respect of each patient under the Accredited Practitioner's care.

(b) The medical record must at a minimum satisfy the standard and requirements set by the Clinic's accreditation agency and licensing body.

(c) In particular, the medical records must include:

(i) an entry in the notes on admission which includes a plan of treatment that details a discharge plan;

(ii) for day patients, a letter of referral to the Clinic on the patient's condition;

(iii) provisional diagnosis;

(iv) therapeutic and diagnostic orders including procedures proposed;

(v) written consent for a procedure;

(vi) particulars of procedures carried out, if any;

(vii) complete anaesthetic records where appropriate including pre-anaesthetic assessments;

(viii) progress observations which detail adequate and meaningful clinical content and changes in orders;

(ix) written medication regimes;

(x) discharge summaries which must be completed in a timely manner and include all information necessary:

(A) to safely discharge the patient; and

(B) for the hospital to collect revenue;

(xi) requests for consultation; and

(xii) any other information relevant to the patient's medical condition.

(d) All entries in the medical record must be clearly legible and include the time and date of the entry, as well as the name, designation and signature of the person making the entry.

(e) All medical records are the property of the Clinic and must not be copied or removed except with the prior approval of the Chief Executive Officer.

6.4 Emergencies

(a) Each Accredited Practitioner acknowledges that in cases of emergency or in other appropriate circumstances, the Clinic may take such action as it deems fit in the interests of a patient which may include a request for attention by an available Medical Practitioner or transfer to another hospital. In such cases, the Clinic will notify the patient's Accredited Practitioner as soon as possible after taking the action.

(b) In cases of emergency, each Accredited Practitioner agrees to assist in the care and treatment of a patient, notwithstanding that the patient is not the responsibility of the Accredited Practitioner.

6.5 Drug, diagnostic and therapeutic orders

(a) An Accredited Practitioner may give drug orders to a registered nurse by telephone provided the order is confirmed by the registered nurse reading the order back to the

Accredited Practitioner.

(b) An Accredited Practitioner who gives such an order must initial the record of the order and enter and sign the order in the medication chart within twenty four hours of the order having been given.

(c) Each Accredited Practitioner must complete written regimes for all medication taken by a patient under his or her care.

(d) Accredited Practitioners are responsible for prescribing drugs for a patient under his or her care. All prescriptions shall be prepared and maintained as required by law.

(e) Accredited Practitioners must give any diagnostic and therapeutic orders in writing.

6.6 Patient death

In the event of the death of a patient, the Clinic will notify the Accredited Practitioner responsible for the patient as soon as possible. The Accredited Practitioner is responsible for pronouncing the patient dead and completing a death certificate or notifying the coroner.

6.7 Consultation

(a) Except as provided for in By-Law 6.1(e), an Accredited Practitioner who wishes for a particular specialist to consult a patient must arrange Temporary Accreditation for the specialist in accordance with By-Law 7.4.

(b) An Accredited Practitioner must record a request for consultation in the patient's medical record. The responsible Accredited Practitioner must comply with a request from the Chief Executive Officer to arrange consultation where there is concern about the patient's condition or management and where such concern is supported by the Chairman of the Medical Advisory Committee or his or her delegate.

6.8 Medical equipment

(a) Accredited Practitioners who supply and use their own equipment:

(i) are responsible for the safety standards of such equipment; and

(ii) must provide to the Chief Executive Officer on a regular basis evidence that the equipment is in good working order and has been checked and is being checked regularly by a qualified technician.

(b) The Accredited Practitioner must be familiar with the safe and proper use of any equipment supplied by the Clinic.

6.9 Mental Health Act Compliance and Electroconvulsive therapy

(a) An Accredited Practitioner must at all times comply with the requirements of the *Mental Health Act (WA)* and regulations as those requirements relate to the Clinic and management of patients admitted to the Clinic, including but not limited to the requirements with respect to decision making capacity (Part 5 Division 1 of the *Mental Health Act (WA)*), informed consent (Part 5 Division 2 and Part 13 Division 1 of the *Mental Health Act (WA))* and electroconvulsive therapy (**ECT**) (Part 14 Division 1 of the *Mental Health Act (WA))*.

(b) An Accredited Practitioner, whether as psychiatrist or anaesthetist, in conducting all aspects in preparation for, during and following ECT should have regard to *The ECT Guide: The Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia 2006* and *Chief Psychiatrist: Practice Standards for the Administration of Electroconvulsive Therapy* (as updated from time to time),

including ensuring the following:

(i) Informed consent must be obtained by Accredited Practitioners from voluntary patients, and must be actively sought prior to any ECT being given or any changes in care delivery. The patient must be advised of their right to withdraw consent at any time.

(ii) All patients should be given sufficient time and the opportunity to seek others' views when making the decision to consent to ECT.

(iii) Accredited Practitioners must not obtain consent for an unlimited duration, and consent must be obtained prior to any new course of treatment.

(iv) Accredited Practitioners must ensure that consent is verbally confirmed prior to every treatment.

(v) Accredited Practitioner must document the consent obtained in the patient's Clinic medical records, and must use the form (as updated from time to time) provided by the Clinic.

Children and adolescents

(c) An Accredited Practitioner must not perform ECT on a child, who for the purposes of performing ECT is a person under 14 years of age.

(d) In the case of an adolescent, who for the purposes of performing ECT is a person who has reached 14 years of age but who is under 18 years of age, the Accredited Practitioner may perform ECT if :

(i) informed consent is given to the ECT; and

(ii) approval has been obtained from the Mental Health Review Tribunal to ECT being performed; and

(iii) in performing the ECT, the Accredited Practitioner complies with the Chief Psychiatrist's Guidelines, which for the purposes of ECT, is *The ECT Guide: The Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia 2006.*

(e) In assessing capacity to consent of an adolescent, the Accredited Practitioner should consider that an adolescent achieves capacity to consent on his or her own behalf when the child or adolescent exhibits maturity in their behaviour sufficient to regard them as functioning at an adult level of decision making, having regard to the complexity of the proposed treatment. It would ordinarily be regarded as an exceptional circumstance that an adolescent is regarded to have sufficient capacity to consent to ECT.

(f) If an adolescent is assessed by the Accredited Practitioner to be competent to make their own health care decisions, they are entitled to make those decisions without involvement of their parent or guardian. A parent or guardian is not entitled to consent to ECT treatment on behalf of the adolescent in these circumstances.

(g) If, in the opinion of the Accredited Practitioner, the adolescent is competent to consent to treatment on his or her own behalf, that adolescent's rights to confidentiality must be respected and permission must be obtained before the proposed treatment is discussed with another person, including the parent or guardian.

(h) If, in the opinion of the Accredited Practitioner, the adolescent is unable to give informed consent or refuses consent, then the Accredited Practitioner should consider whether the patient should be admitted to a public mental health hospital as an involuntary patient.

Adults

(i) Prior to administering ECT on an adult, who for the purposes of performing ECT is a person has attained 18 years of age, an Accredited Practitioner must obtain the informed consent of the patient to the ECT (including if continuation or maintenance therapy is proposed) and anaesthesia.

(j) The Accredited Practitioner must have regard to the Chief Psychiatrist's Guidelines which for the purposes of ECT is *The ECT Guide: The Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia 2006.*

6.10 Approval for New Clinical Service

(a) A New Clinical Service means clinical services, treatment, procedures, techniques, technology, instruments or other interventions that are being introduced into the organisational setting of the Clinic for the first time, or if currently used are planned to be used in a different way, and that depend for some or all of their provision on the professional input of an Accredited Practitioner.

(b) Before treating a patient of the Clinic with a New Clinical Service, an Accredited Practitioner is required to obtain the prior written approval of the Chief Executive Officer and what is proposed must fall within the Accredited Practitioner's Scope of Clinical Practice or an extension to the Scope of Clinical Practitioner has been obtained, and it must fall within the service capacity of the Clinic.

(c) The Accredited Practitioner must provide evidence of Adequate Professional Indemnity Insurance to cover the New Clinical Service and, if requested, evidence that private health funds will adequately fund the New Clinical Service.

(d) If research is involved, the requirements relating to research must be complied with.

(e) There is no right of appeal from a denial of a request to conduct a New Clinical Service.

6.11 Obligations of Accredited Practitioners

Each Accredited Practitioner:

(a) shall use his or her best endeavours to achieve the objectives of the Clinic specified in By-Law 1.2;

(b) agrees to be bound by and comply with the By-Laws, the Rules and Regulations, the Clinic's policies and procedures, the patient charter of rights, the *Mental Health Act (WA)* and regulations, directives, policies and standards (however named) issued by the Office of the Chief Psychiatrist and the Department of Health WA;

(c) agrees to abide by the codes of conduct and behaviour of the Clinic, and the values adopted by the Clinic, which at a minimum includes acting professionally and courteously toward Clinic staff and contractors, other Accredited Practitioners, patients and families of patients, and all other persons on the premises of the Clinic, and complying with all laws with respect to anti-discrimination, bullying and harassment;

(d) shall treat patients within the limits of that Accredited Practitioner's Accreditation;

(e) will practice only within the Scope of Clinical Practice approved by the Clinic;

(f) shall comply with the conditions of Accreditation, including any special conditions which may be imposed by the Executive Committee or in the case of Temporary Accreditation, the Chief Executive Officer;

(g) agrees to obtain the prior informed consent of a patient where that is expected in accordance with accepted medical and legal standards, with the consent to be in writing and signed by the patient;

(h) agrees to obtain informed financial consent in relation to the fees of the Accredited Practitioner;

(i) shall report to the Clinic incidents (including near misses), notifiable incidents required to be reported to the Chief Psychiatrist and/or the Department of Health WA, complications, adverse events and complaints relating to the Clinic's patients in accordance with the Clinic's policy and procedures and where requested by the Clinic will assist with incident management, investigations and reviews (including root cause analysis and other system reviews), complaints management and open disclosure processes;

(j) will provide all reasonable and necessary assistance in circumstances where the Clinic requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction, including for example where that direction is pursuant to a court order, from a health complaints body, Coroner, Police, State Health Department and its agencies or departments, State Private Health Regulatory/Licensing Unit, the Commonwealth Government and its agencies or departments;

(k) shall comply with all the standards required or set by the Clinic's accreditation agency and with all other standards set by an authority having control or jurisdiction of the Clinic;

(l) shall comply with, and take all reasonable actions to assist the Clinic to comply with, each of the National Safety and Quality Health Service Standards issued by the Australian Commission on Safety and Quality in Health Care and any associated clinical guidelines;

(m) will continually maintain registration with the relevant registration body and provide evidence of the registration to the Chief Executive Officer on renewal of the registration each year;

(n) shall continually maintain Adequate Professional Indemnity Insurance, with that insurance to also satisfy the provisions of any relevant legislation including the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth) and the *Medical Indemnity (Prudential Supervision and Product Standards) Regulations 2003* (Cth), against professional negligence and other related claims and provide evidence of the indemnity to the Chief Executive Officer each year on renewal of the indemnity;

(o) shall provide professional services with due skill, care and diligence and adhere to the generally accepted ethics and standards of personal conduct expected of health care professionals; and

(p) shall comply with the provisions of the Privacy Amendment (Enhancing Privacy Protection) Act 2012, Australian Privacy Principles and other relevant State laws regulating private hospitals.

6.12 Safety and quality

(a) Every Accredited Practitioner must assist the Clinic and participate in the Clinic's Quality Assurance Programmes including activities required by the Accreditation standards of the Clinic's accreditation agency.

(b) Every Accredited Practitioner must comply with, and take all reasonable actions to assist the Clinic to comply with, each of the National Safety and Quality Health Service Standards issued by the Australian Commission on Safety and Quality in Health Care, including participating in education and training in relation to the Standards.

(c) Every Accredited Practitioner must comply with the requirements of the Clinic's governance system, including but not limited to policies, procedures and protocols relating to establishing and maintaining a clinical governance framework, identifying and reporting safety and quality risks, collecting and reviewing performance data, implementing prevention strategies based on data analysis, analysing reported incidents, implementing performance management procedures, ensuring compliance with legislative requirements and relevant industry standards, communicating with and informing the clinical and non-clinical workforce, and supporting the undertaking of regular clinical audits.

(d) Accredited Practitioners must participate in organised educational activities of the Clinic.

(e) Accredited Practitioners are encouraged to participate in regular peer review in relation to patients of the Clinic.

6.13 Resistant staphylococcus aureus policy

Every Accredited Practitioner shall observe and follow the Methicillin Resistant Staphylococcus Aureus policy in respect of all patients under his or her care who have been in hospital either interstate or overseas in the twelve months preceding the date of admission to the Clinic.

6.14 Ethics and confidential information

An Accredited Practitioner must:

(a) observe the *Code of Ethics* of the Australian Medical Association and the *Good Medical Practice: A Code of Conduct for Doctors in Australia* of the Medical Board of Australia;

(b) obtain the approval of a recognised ethics committee before any medical research or clinical trial in which the Accredited Practitioner is named as an investigator is undertaken in the Clinic, and thereafter conduct the medical research or clinical trial in accordance with the approval, National Health and Medical Research Council requirements, National Statement on Ethical Conduct in Human Research and other applicable legislation and standards;

(c) hold in strictest confidence all Confidential Information; and

(d) not divulge any Confidential Information without the written consent of the Executive Committee, except for the purpose of obtaining legal advice or under compulsion of law.

6.15 Use of Perth Clinic name and communication with media

Unless an Accredited Practitioner has the prior written approval of the Chief Executive Officer, the Accredited Practitioner must not use Perth Clinic letterhead, in any way hold out that the Accredited Practitioner represents the Clinic, or communicate with the media regarding any matter involving the Clinic or a patient of the Clinic.

6.16 Notifications

An Accredited Practitioner must promptly notify the Chief Executive Officer, and follow up in writing within 2 days of the notification event occurring or the Accredited Practitioner first becoming aware of the notification event, if any of the following events occur:

(a) Legal proceedings are commenced against the Accredited Practitioner;

(b) An investigation is commenced or notification is received about a complaint being lodged in relation to the Accredited Practitioner, or about his/her patient (irrespective of whether this relates to a patient of the Clinic), by the Accredited Practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency;

(c) An adverse finding (including but not limited to criticism or adverse comment about the care or services provided by the Accredited Practitioner) is made against the Accredited Practitioner by a civil court, the Accredited Practitioner's registration board or disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency, irrespective of whether this relates to a patient of the Clinic;

(d) The Accredited Practitioner's professional registration is revoked, suspended or amended, conditions are imposed, any limitation is placed on the Accredited Practitioner's registration or right to practice, or undertakings agreed, irrespective of whether this relates to a patient of the Clinic and irrespective of whether this is noted on the public register;

(e) Professional indemnity membership or insurance is made conditional or not renewed, should limitations be placed on professional indemnity membership or insurance, or the Accredited Practitioner ceases to be fully indemnified by his or her medical defence organisation or professional indemnity insurer, for any reason;

(f) The Accredited Practitioner's appointment, clinical privileges or Scope of Clinical Practice at any other facility, clinic or hospital is altered in any way, including if it is withdrawn, suspended, restricted or made conditional, and including whether this was done by way of agreement;

(g) Any physical or mental condition or substance abuse problem occurs that could affect the Accredited Practitioner's ability to practise or that would require any special assistance to enable the Accredited Practitioner to practise safely and competently;

(h) The Accredited Practitioner is charged with having committed or is convicted of a sex, violence or indictable criminal offence. The Accredited Practitioner must provide the Clinic with an authority to conduct at any time a criminal history check with the appropriate authorities;

(i) The Accredited Practitioner believes that patient care or safety is being compromised or at risk, or may potentially be compromised or at risk, by another Accredited Practitioner at the Clinic;

(j) the Accredited Practitioner makes a mandatory notification to a health practitioner registration board (for example the Medical Board of Australia) in relation to another Accredited Practitioner of the Clinic; or

(k) the Accredited Practitioner contracts a communicable disease or is diagnosed with a medical condition that has the potential to impact upon patient or staff safety.

6.17 Continuous disclosure

The Accredited Practitioner must keep the Chief Executive Officer continuously informed of every fact and circumstance which has, or will likely have, a material bearing upon:

(a) the Accreditation of the Accredited Practitioner;

(b) the Scope of Clinical Practice of the Accredited Practitioner;

(c) the ability of the Accredited Practitioner to safely deliver health services to his/her patient within the Scope of Clinical Practice;

(d) the Accredited Practitioner's registration or professional indemnity insurance arrangements;

(e) the inability of the Accredited Practitioner to satisfy a medical malpractice or professional indemnity claim by a patient of the Clinic;

(f) adverse outcomes, complications or complaints in relation to the Accredited Practitioner's patients (current or former) of the Clinic;

(g) the reputation of the Accredited Practitioner as it relates to the provision of Clinical Practice at the Clinic; or

(h) the reputation of the Clinic.

7. ACCREDITATION PROCESS

7.1 Eligibility

To be eligible for the grant of Visiting Rights and Privileges a Medical Practitioner must:

(a) have a current unconditional registration by the Medical Board of Australia;

(b) hold Adequate Professional Indemnity Insurance and be indemnified in accordance with the provisions of any relevant legislation including the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth) and the *Medical Indemnity (Prudential Supervision and Product Standards) Regulations 2003* (Cth) against professional negligence and other related claims;

(c) if seeking to practice at the Clinic as a specialist, be registered in that speciality by the Medical Board of Australia;

(d) have no disciplinary action pending;

(e) agree to the Executive Committee seeking references from persons other than those nominated by the Medical Practitioner;

(f) agree to abide by the Clinic By-Laws, Rules and Regulations, code of conduct, policies or procedures; and

(g) provide with the Application evidence that:

(i) the Medical Practitioner's registration is current and unconditional; and

(ii) the Medical Practitioner holds Adequate Professional Indemnity Insurance and is indemnified in accordance with the provisions of any relevant legislation including the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth) and the *Medical Indemnity (Prudential Supervision and Product Standards) Regulations 2003* (Cth); and

(h) agree to provide any other information and evidence relevant to the Application which may be requested by the Executive Committee or the Medical Advisory Committee.

7.2 Applying for Accreditation

(a) All Applications should be submitted to the Chief Executive Officer who must promptly forward the Application to the Medical Advisory Committee.

(b) The Medical Advisory Committee must recommend to the Executive Committee whether or not the Medical Practitioner should be granted Accreditation, the appropriate Scope of Clinical Practice, and whether or not the Executive Committee should impose any special conditions on the Accreditation.

(c) Upon receiving the Medical Advisory Committee's recommendation, at the next scheduled meeting of the Executive Committee, the Executive Committee will determine by resolution of a simple majority of its members, whether or not the Accreditation is granted, the appropriate Scope of Clinical Practice, and if any special conditions are imposed on the Accreditation.

(d) The Executive Committee must notify the Medical Practitioner of its determination within 10 Business Days of the meeting at which the determination was made. The Executive Committee is not required to provide the Medical Practitioner with reasons for its determination.

(e) Decision making in relation to applications for Accreditation will include, but are not limited to, consideration of Credentials, Organisational Capability and Organisational Need.

(f) For the avoidance of doubt:

(i) nothing in these By-Laws requires the Executive Committee to grant Accreditation to a Medical Practitioner who has made an Application; and

(ii) the Executive Committee is not bound by any recommendation of the Medical Advisory Committee.

7.3 Re-application for Accreditation

(a) An Accredited Practitioner whose term of appointment is due to expire may re-apply for Accreditation by completing the relevant abbreviated part of the Application.

(b) In addition to the eligibility requirements set out in By-Law 7.1 above, to be eligible for re-application for Accreditation, an Accredited Practitioner must, in the reasonable opinion of the Executive Committee, during the immediately previous term of Accreditation, have:

(i) complied with each of the conditions specified in By-Law 6;

(ii) exhibited satisfactory Performance and Competence;

(iii) exhibited no patterns of adverse clinical outcomes; and

(iv) exercised their Visiting Rights or Privileges at least once in a continuous 12 month period.

7.4 Temporary Accreditation

(a) Upon Application by a Medical Practitioner, the Chief Executive Officer may grant Temporary Accreditation to the Medical Practitioner for a maximum period of 30 days.

(b) Prior to granting Temporary Accreditation, the Chief Executive Officer must consult with a member of the Medical Advisory Committee.

(c) The Chief Executive Officer may terminate Temporary Accreditation at any time without any rights of appeal.

(d) If an Accredited Practitioner wishes to recruit a locum tenens to cover a period of absence, the Accredited Practitioner must ensure that the locum tenens applies for Temporary Accreditation at least 10 Business Days prior to the Accredited Practitioner's period of absence.

7.5 Accreditation for Electroconvulsive Therapy

In addition to satisfying the general requirements for Accreditation, the additional requirements to satisfy for an applicant seeking initial Accreditation for electroconvulsive therapy are:

(a) Evaluation of the Medical Practitioner's professional involvement in electroconvulsive therapy, which may, depending on the circumstances include:

(i) education and training in modern electroconvulsive therapy practice, including the use of EEG monitoring, at a recognised electroconvulsive therapy training program;

(ii) continuing medical education activities, including but not limited to developments in the field in terms of research, advances in technique, and evolving indications for the use of electroconvulsive therapy;

(iii) experience in personally delivering electroconvulsive therapy in order to demonstrate maintenance of an active electroconvulsive therapy practice;

(iv) any other relevant activities, including but not limited to teaching and supervising electroconvulsive therapy, development of local electroconvulsive therapy protocols, reviewing or writing journal articles about electroconvulsive therapy; and/or

(v) completion of the Clinic's self directed learning package on electroconvulsive therapy; or

(b) Assessment of electroconvulsive therapy technique by the ECT Director of the Clinic (or nominee), which involves observing the Medical Practitioner giving at least 10 electroconvulsive therapy treatments to ascertain that his or her technique is in the opinion of the ECT Director of the Clinic (or nominee) adequate and meets the requirements of the Clinic in the following areas:

(i) EEG monitoring;

(ii) all types of electroconvulsive therapy techniques (including but not limited to stimulus dosing and variations in electrode placement) relevant to the service provided by the Clinic;

(iii) titration of seizure threshold and stimulus dosing;

(iv) manipulation of all electroconvulsive therapy machine settings; and

(v) awareness of the anaesthetic aspects of the treatment.

7.6 Re-application for Accreditation for Electroconvulsive Therapy

In addition to satisfying the general requirements for re-application for Accreditation, the Accredited Practitioner will demonstrate to the satisfaction of the Clinic:

(a) Personal performance of at least 25 electroconvulsive therapy treatments in each 12 month period; and

(b) Evidence of continuing education professional development specific to electroconvulsive therapy; and

(c) Participation in review by the ECT Director of the Clinic in each 12 month period, during which the Accredited Practitioner's competency as set out in By-Law 7.5(b) is re-assessed and which is in opinion of the ECT Director of the Clinic adequate and meets the requirements of the Clinic.

8. VARIATION, SUSPENSION OR TERMINATION OF ACCREDITATION

8.1 Visiting Rights and Privileges: automatically revoked

(a) An Accredited Practitioner's Accreditation is automatically revoked if and when:

(i) the Accredited Practitioner ceases to be registered with his or her relevant registration board;

(ii) in the case of a psychiatrist, if the Accredited Practitioner ceases to be a Fellow of the Royal Australian and New Zealand College of Psychiatrists;

(iii) the Accredited Practitioner ceases to maintain Adequate Professional Indemnity Insurance covering the Scope of Clinical Practice or ceases to be indemnified in accordance with the provisions of any relevant legislation including the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth) and the *Medical Indemnity (Prudential Supervision and Product Standards) Regulations 2003* (Cth) against professional negligence and related claims; or

(iv) a term or condition that attaches to an approval of Accreditation is breached, not satisfied, or according to that term or condition results in the Accreditation concluding.

8.2 Practitioner may request variation or suspension of Accreditation

(a) An Accredited Practitioner may apply for variation of the category or of any condition of their Accreditation (except the common conditions set out in By-Law 6) by completing the relevant abbreviated part of the Application.

(b) An Accredited Practitioner may request the Chief Executive Officer to suspend Accreditation for a period up to 12 months for a good cause, for example, study leave, so as to preserve the Medical Practitioner's right to automatically resume exercising Visiting Rights or Privileges at the end of the period without having to re-apply for Accreditation or without threat of revocation of Accreditation for non-use.

8.3 Executive Committee may vary, suspend or revoke Accreditation

(a) The Executive Committee may, by written notice to an Accredited Practitioner, vary, suspend or revoke an Accredited Practitioner's Accreditation at any time, or apply conditions to Accreditation, if, in the opinion of the Executive Committee, the following has occurred in relation to the Accredited Practitioner:

(i) fails to observe the terms and conditions upon which Accreditation was granted (including the common conditions set out in By-Law 6);

(ii) fails to observe the Clinic By-Laws, Rules and Regulations, policies or

procedures, the *Mental Health Act (WA)* and regulations, or directives, policies and standards (however named) issued by the Office of the Chief Psychiatrist and/or the Department of Health WA;

(iii) engages in unprofessional conduct or breaches the code of conduct either at the Clinic or in their medical practice generally;

(iv) demonstrates a lack of Competence in practising medicine, regardless of whether or not the conduct occurs at the Clinic or elsewhere;

(v) is performing at a standard below that which the Clinic requires;

(vi) becomes incapacitated from performing his or her duties for a continuous period of six months or more;

(vii) the Accredited Practitioner is not regarded as having the appropriate Current Fitness to retain Accreditation or the Scope of Clinical Practice;

(viii) there is a finding of professional misconduct, unprofessional conduct, unsatisfactory professional conduct or some other adverse professional finding (however described) by a registration board or other relevant disciplinary body or professional standards organisation;

(ix) the Accredited Practitioner's professional registration is amended, or conditions imposed, or undertakings agreed, irrespective of whether this relates to a current or former patient of the Clinic;

(x) conditions have been imposed by the Accredited Practitioner's registration board on Clinical Practice that restricts practice and the Clinic does not consider that it has the capacity to accommodate the conditions imposed;

(xi) the Accredited Practitioner has made a false declaration or provided false or inaccurate information to the Clinic, either through omission of important information or inclusion of false or inaccurate information;

(xii) the Accredited Practitioner fails to make the required notifications required to be given pursuant to these By-laws;

(xiii) based upon a notification given pursuant to By-Law 6.16 or 6.17;

(xiv) the Accreditation, clinical privileges or Scope of Practice of the Accredited Practitioner has been suspended, terminated, restricted or made conditional by another health care organisation;

(xv) the Accredited Practitioner is the subject of a criminal investigation about a serious matter (for example a drug related matter, or an allegation of a crime against a person such as a sex or violence offence) which, if established, could affect his or her ability to exercise his or her Scope of Clinical Practice safely and competently and with the confidence of the Clinic and the broader community;

(xvi) the Accredited Practitioner has been convicted of a crime which could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Clinic and the broader community;

(xvii) based upon a finalised Internal Review or External Review pursuant to these By-laws;

(xviii) an Internal Review or External Review has been initiated pursuant to these By-laws and the Executive Committee considers that an interim suspension is appropriate pending the outcome of the review;

(xix) the Accredited Practitioner has not exercised Accreditation or utilised the facilities at the Clinic for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Accredited Practitioner;

(xx) the Scope of Clinical Practice is no longer supported by Organisational Capability or Organisational Need; or

(xxi) there are other unresolved issues or other concerns in respect of the Accredited Practitioner that is considered to be a ground for variation, suspension, revocation or imposition of conditions.

(b) In varying the Accredited Practitioner's Accreditation, the Executive Committee may impose special conditions on the Accredited Practitioner's Accreditation.

8.4 Chief Executive Officer may suspend Accreditation

(a) Subject to By-Law 8.4(b) below, the Chief Executive Officer may at any time suspend the Accreditation of an Accredited Practitioner if the Chief Executive Officer reasonably believes that, after consultation with the Chair of the Medical Advisory Committee:

(i) the Accredited Practitioner has or continues to compromise patient care or safety;

(ii) it is in the interests of patient care or safety. This can be based upon an investigation by an external agency including a registration board, disciplinary body, Coroner or health complaints body, and may be related to a patient or patients at another facility not operated by the Clinic;

(iii) it is in the interests of staff welfare or safety;

(iv) the Accredited Practitioner has or continues to breach any of the common conditions set out in By-Law 6;

(v) the Accredited Practitioner has or continues to breach any of the special conditions applicable to the Accredited Practitioner.

(vi) the continuance of the current Scope of Clinical Practice raises a significant concern about the safety and quality of health care to be provided by the Accredited Practitioner;

(vii) the behaviour or conduct of the Accredited Practitioner is in breach of a direction or an undertaking, constitutes unprofessional conduct or breaches the code of conduct either at the Clinic or in their medical practice generally, is bringing the Clinic into disrepute, or is unduly hindering the efficient operation of the Clinic; or

(viii) the Accredited Practitioner has been suspended by his or her registration board.

(b) In suspending an Accredited Practitioner, the Chief Executive Officer must give the Accredited Practitioner written notice which sets out:

(i) the period of suspension;

(ii) the reasons for the suspension; and

(iii) actions which the Accredited Practitioner must take, and the timeframe for taking those actions, for the suspension to cease.

8.5 Review or audit of Accreditation

(a) The Chief Executive Officer or the Executive Committee may at any time initiate a review of an Accredited Practitioner's Accreditation, including but not limited to Current Fitness, Competence, Performance and compliance with the conditions of Accreditation at the Clinic.

(b) The process for review may be by way of internal review, external review or patient audit.

(c) In the case of an internal review or external review, the reviewer must prepare a report (***Review Report***) which sets out findings in accordance with the terms of reference, which may include:

(i) an Accredited Practitioner's Current Fitness to retain Accreditation;

(ii) an Accredited Practitioner's Competence to retain Accreditation

(iii) an Accredited Practitioner's Performance at the Clinic;

(iv) an Accredited Practitioner's compliance with the By-laws or conditions of Accreditation; and

(v) any specific questions in respect of the matters in this By-Law 8.5 which the Chief Executive Officer or the Executive Committee refers for review.

(d) The Review Report must also include recommendations as to whether the Executive Committee should continue, vary, suspend or revoke the Accredited Practitioner's Accreditation.

(e) The Executive Committee must consider the findings and recommendations of a Review Report in deciding whether to continue, vary, suspend or revoke an Accredited Practitioner's Accreditation.

(f) The Accredited Practitioner who is the subject of the review may obtain a copy of the Review Report on written request to the Chief Executive Officer.

8.6 Internal review

(a) An internal review is undertaken by the Medical Advisory Committee.

(b) Upon request to conduct an internal review, the Medical Advisory Committee must, within 2 Business Days, appoint two Medical Practitioners to conduct the review (***Reviewing Medical Practitioners***). The Reviewing Medical Practitioners must be persons who do not have an interest in the outcome of the review.

(c) Within 10 Business Days of the Reviewing Medical Practitioners' appointment:

(i) the Reviewing Medical Practitioners must complete a draft Review Report; and

(ii) the draft Review Report must be circulated to each member of the Medical Advisory Committee.

(d) At the next Medical Advisory Committee meeting following circulation of the draft Review Report, the Medical Advisory Committee (by resolution of a simple majority of its members) may endorse the report with or without amendment. If the Medical Advisory Committee proposes to substantively amend the Draft Review Report, it must first consult with, and consider the views of, the Reviewing Medical Practitioners.

(e) As soon as practicable after endorsing the Review Report, the Medical Advisory Committee must provide a copy to the Executive Committee for consideration by the Executive Committee in accordance with By-Law 8.5.

8.7 External review

(a) An external review is undertaken by a person independent of the Clinic and of the Accredited Practitioner in question.

(b) The Clinic selects and engages the independent reviewer and bears the costs of the external review.

(c) The Independent Reviewer must provide a Review Report to the Executive Committee within 28 Business Days of appointment, or such other time as may be agreed between the Independent Reviewer and the Chief Executive Officer, for consideration by the Executive Committee in accordance with By-Law 8.5.

8.8 Patient audit

(a) The Clinic, at the direction of the Chief Executive Officer may, at any time, with or without notice to the Accredited Practitioner, conduct an audit of an Accredited Practitioner's patient files to assess the Accredited Practitioner's patient care and compliance with Clinic By-Laws, Rules and Regulations, policies and procedures (***Patient Audit***).

(b) If an Accredited Practitioner is aware that the Clinic is conducting a Patient Audit, the Accredited Practitioner must:

(i) co-operate fully with the Clinic; and

(ii) not disclose the existence of the Patient Audit to any other person without prior authorisation to do so from the Chief Executive Officer.

(c) The Chief Executive Officer must present any findings from the Patient Audit to the first meeting of the Executive Committee that occurs after the completion of the Patient Audit for consideration by the Executive Committee in accordance with By-Law 8.5.

8.9 Co-operation required

(a) If an Accredited Practitioner's Accreditation is varied, suspended or revoked for any reason before the expiry of the stated term, the Accredited Practitioner is required to co-operate with the Clinic and to provide patient data and information to the Clinic, including patient data and information reasonably necessary to allow the Clinic to collect revenue. In particular, the Accredited Practitioner must ensure that all discharge summaries are completed.

(b) This condition survives the suspension or revocation of the Accredited Practitioner's Accreditation and is a continuing obligation on the Accredited Practitioner.

8.10 Appeal against Accreditation decision

(a) Subject to By-Law 8.10(d) below, an Accredited Practitioner may appeal a decision of the Executive Committee to refuse a re-Application for Accreditation, or vary, suspend or revoke Accreditation.

(b) A Medical Practitioner who has been refused Accreditation on a new Application or whose Temporary Accreditation has been terminated by the Chief Executive Officer has no rights of appeal under these By-Laws.

(c) If the Accredited Practitioner's Accreditation is suspended in accordance with By-Law 8.4, the Accredited Practitioner must have unsuccessfully appealed the Chief Executive Officer's decision to the Executive Committee before he or she may appeal under this By-Law.

(d) An Accredited Practitioner wishing to commence an appeal under this By-Law must notify the Chief Executive Officer in writing within 10 Business Days of the Executive Committee's decision to refuse a re-application for Accreditation or vary, suspend or revoke Accreditation. For the purpose of this By-Law, a Medical Practitioner who commences an appeal is an ***Appellant***.

(e) Within 5 Business Days of receiving notice pursuant to By-Law 8.10(d), the Chief Executive Officer must arrange for persons to sit on a panel to hear the appeal (***Appeal Panel***). The Appeal Panel is comprised of:

(i) a nominee of the Executive Committee who is not a member of the Executive Committee;

(ii) a nominee of the Medical Advisory Committee who is not a member of the Medical Advisory Committee; and

(iii) a nominee of the appropriate professional college of the Appellant.

(f) Upon confirming the Appeal Panel members, the Chief Executive Officer must schedule a date for the hearing of the appeal.

(g) The Chief Executive Officer must provide each of the Executive Committee and the Appellant at least 10 Business Day's notice in writing of the date of the appeal hearing.

(h) Each of the Executive Committee and the Appellant may make written submissions in respect of the appeal, provided that the Appeal Panel and the other party receives those written submissions no later than 5 Business Days before the hearing.

(i) Each of the Executive Committee and Appellant may make oral submissions at the hearing. Each party may appoint two persons to attend at the hearing and either person or both of those two persons may make the oral submissions on behalf of the party they represent.

(j) Neither the Executive Committee nor the Appellant is permitted legal representation at the hearing. The hearing of the Appeal Panel is a closed session.

(k) The Appeal Panel may conduct the hearing and accept or reject evidence as it sees fit.

(l) Within 5 Business Days of the appeal, the Appeal Panel must recommend to the Board whether the Clinic should uphold or vary the original decision regarding accreditation. The Appeal Panel is required to provide to the Board reasons for its recommendation

(m) At the first Board meeting after receiving the recommendation from the Appeal Panel, the Board must decide whether to uphold or vary the original decision regarding accreditation.

(n) The Chief Executive Officer must notify each of the Executive Committee and Appellant of the Board's decision.

(o) The Board's decision shall be final and binding on all parties and is not subject to appeal.

(p) The Board is not required to provide reasons for its decision.

9. AMENDMENTS

(a) These By-Laws may be amended from time to time by a resolution of a simple majority of members of the Executive Committee.

(b) Either the Medical Advisory Committee or the Chief Executive Officer may propose amendment to the By-Laws at any time.