BY LAWS

HOSPITAL AND MEDICAL BY LAWS

Documents relating to Western Gastroenterology Services are available in the Western Gastroenterology Services QM-Quality Manual.

1. Organisational Role and Function (QM-01 Quality Manual-Governance)
2. Quality Objectives (QM-01 Quality Manual-Governance)
3. Organisation and Lines of Communication (QM-01 Quality Manual-Governance)
4. Policies and Procedures, including patient safety (QM-01 Quality Manual-Governance & QM-02 Quality Manual-Clinical Practice)
5. Mission Statement (QM-01 Quality Manual-Governance)
6. Governance and Quality Improvement Systems (QM-01 Quality Manual-Governance)
7. Governance of Roles and Responsibilities for Safety and Quality Healthcare (QM-01 Quality Manual-Governance)
8. Risk management – Clinical Governance (QM-01 Quality Manual-Governance & QM-02 Quality Manual-Clinical Practice)
9. Medication management – (QM-01 Quality Manual-Governance & QM-02 Quality Manual-Clinical Practice)

CONDITIONS

Every Medical Practitioner granted membership to the medical staff shall abide by the Medical Staff By-laws and Rules in addition to providing continuous care and supervision of his/her patients.

All applicants for clinical privileges must hold the following:

1. Registration with Australian Health Practitioner Registration Authority
2. Three appropriate references as to professional qualifications;
3. Medical Defence (Professional Indemnity) cover
4. Evidence of ongoing clinical education (or programmes) for the maintenance of professional standards as designated by the appropriate College

1. DETERMINATION OF CLINICAL PRIVILEGES: [1]

Subject to Western Gastroenterology Service, Department of Human Services Registration.

Accredited Medical Practitioners shall be entitled to exercise only those clinical privileges specifically granted by the Board of Directors (Management Review), see QP-01-08 Credentialing of Medical and Nursing Staff Procedure.

Accredited Medical Practitioners shall be granted privileges to admit and treat patients, subject to the provisions of these By-Laws and QP-01-08 Credentialing of Medical and Nursing Staff).

1. **Surgical Privileges**
   Medical practitioners who possess the FRACS, or equivalent qualification, and are registered as a Specialist general surgeon with AHPRA

[1] List of Medical Specialities, fields of speciality practice and related medical titles, Medical Board of Australia, effective July 2010

2. **Physician Privileges**
   Medical practitioners who are registered as a Specialist physician or Specialist gastroenterologist and hepatologist with AHPRA

   Please Note - Gastrointestinal Endoscopy Privileges
   A Specialist with an appropriate post graduate degree must supply evidence of accreditation in requested practice area by the Conjoint Board on Endoscopy Training. Accreditation may be restricted to certain types of endoscopic procedures.

3. **Urological Privileges**
   Medical practitioners who are registered as a Specialist urologist with AHPRA

4. **Anaesthetic Privileges**
   Medical practitioners who are registered as a Specialist anaesthetist with AHPRA.

5. **General Practitioner Privileges**
   Medical practitioners who are registered as a Specialist general practitioner with AHPRA will be granted to treat patients within the framework or limitations as follows.

   Practitioners administering sedation to patients undergoing gastrointestinal endoscopic procedures must meet the recommendations of the Gastrointestinal Society of Australia, the Royal Australian College of Anesthetists, and the Royal Australasian College of Surgeons guidelines as outlined in their publication "Guidelines on Sedation for Gastrointestinal Procedures"

   Appointments are made for a maximum term of three years.

CATEGORIES OF THE MEDICAL STAFF
The only category of medical staff is that of Accredited Staff.

ACCREDITED MEDICAL PRACTITIONER RESPONSIBILITIES
The Accredited Medical Practitioner

1. Will have full professional responsibility for their patients.
2. Will behave in a professional and ethical manner at all times.
3. Will be required to conform to the prescribed By-Laws and Protocols concerning practice at Western Gastroenterology Services.
4. Must show a commitment to continuing education and agree to participate in peer review and quality assurance with the Hospital.
5. Must be committed to teaching staff.
6. Will restrict activities to those procedures for which they are accredited.
7. Will advise the Medical Director of any withdrawal of competency or restriction on activities made by the Medical Board of Victoria or a national body for certification of competence in their discipline.

CLINICAL RESPONSIBILITIES

1. The Responsible Medical Practitioner is to ensure that the consent of all patients to all treatment, medical, surgical and otherwise is obtained prior to the treatment being undertaken.

2. The Responsible Medical Practitioner is to ensure that all Patients admitted by them have made arrangements to be accompanied home by a responsible adult.

3. The Responsible Medical Practitioner shall record in the patient's notes a statement of diagnosis and relevant medical notes during the time of admission.

4. A statement of discharge diagnosis and medication shall be clearly written in the patient's notes by the medical practitioner directing such treatment.

5. Telephone orders will be accepted by the nurse in charge only, and signed by Doctor within 24 hours.

6. The Responsible Medical Practitioner will ensure that all Patients have adequate written discharge instructions.

7. In an Emergency

The Hospital is authorised to take such action as it sees fit in the interests of the patient. This may include a request for attention by an available medical practitioner.

The following provisions will apply:

a) The patient's medical practitioner will be advised of the circumstances of the emergency and action taken at the earliest possible opportunity.
b) The responsible Medical Practitioner will resume the care of the patient as soon as possible.

CONDUCT OF PROCEDURES

1. Procedures shall be undertaken in accordance with relevant professional body governing medical practitioner conduct.

2. Practitioners will negotiate sessions with the DON and Executive Director subject to availability and in anticipation of patient load and expressions of interest.

3. If utilisation drops below a reasonable level of time allocated, the Hospital reserves the right to re-negotiate sessional time, after consultation with the medical practitioner concerned.

4. Cancellation of a procedure list should occur only if reasonable notice of cancellation has been provided.

5. The Hospital reserves the right to make open access bookings for any session or part thereof where vacancies exist according to demand.

6. The patient's name, nature of the procedure, Insurance status and the patient's age shall be notified to reception the day before a procedure session.

7. Anaesthetic/Sedation
   a) The Visiting Medical Practitioner shall ensure that the necessary liaison with the Anaesthetist takes place for the proper pre and post- operative care of the patient.

   b) The administration of anaesthetic/sedation to a patient shall be given only by, or under the direct supervision of the Anaesthetist.

   c) The Anaesthetist shall, before leaving the Hospital, review the post-procedure Patients and assess their clinical status.

   d) The Anaesthetist will ensure that prior to leaving the Facility that all Patients are safe to be discharged after a minimum of 60 minutes recovery time.

e) The Anaesthetist will ensure that they are immediately contactable by the facility until all Patients under their care have been discharged.

PROVISION OF STAFF, EQUIPMENT AND MAINTENANCE

1. The Hospital shall ensure that adequate and competent nursing care is provided when and where necessary.

2. The Hospital shall provide appropriate equipment and ensure that such is maintained in good working order; checked at regular intervals; and operated by trained and approved personnel.

3. The hospital shall provide for maintenance and regular checking of all emergency equipment.

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT – (see also QP-01-08 Credentialing of Medical & Nursing Staff)

APPLICATION FOR APPOINTMENT

Applications for appointment to the medical staff shall be submitted on the Application Form and will be submitted for approval by the Medical Advisory Committee. For Anaesthetist applicant the MAC member anaesthetist will check and for Endoscopies will check by one MAC member who is endoscopies. Then sign by CEO.

The Application Form, approved by the Medical Advisory Committee will incorporate qualifications and three referees of the applicant, state the privileges requested, and agreement by the applicant to abide by the Medical By-laws.

Applications for appointment signify the applicant's willingness to appear for interviews in regard to his/her application and authorises the Hospital to consult with other members of medical staff of other Hospitals about the application.

The applicant consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges she/he requests, as well as his/her moral and ethical qualifications for staff membership.

All applicants not meeting these requirements must present a list of procedures for the purpose of delineation of privileges.

The applicant will be notified by the Chief Executive Officer as soon as possible of the result of their application.

REAPPOINTMENT PROCESS

The Chief Executive Officer shall, at least 90 days prior to the expiration date of the present staff appointment for each medical staff member, provide the Medical Practitioner member with an application form for reappointment form prior to the expiration date of the present appointment, in order to maintain up to date information in regard to the Medical Practitioners.

Upon receipt and verification of information contained in the application for reappointment form the Chief Executive Officer will transmit the information to the Medical Advisory Committee for approval.

APPEAL PROCESS

The Chief Executive Officer will notify the Practitioner as to the decision in consultation with the Medical Advisory Committee regarding his/her application for medical staff membership.

Request for Appeal
If the recommendation of the Medical Advisory Committee and/or the Chief Executive Officer is adverse to the applicant, the applicant may, within thirty (30) days, request a hearing with the Medical Advisory Committee.

After the hearing the Medical Advisory Committee will further discuss the application. The decision of that meeting will be circulated to the applicant within thirty days by the Chief Executive Officer.

Failure of the applicant to be present at the hearing will constitute a withdrawal of the request for appeal. If no written notification of appeal is received within thirty (30) days of the notification of the decision of the Board of Directors, the applicant waives his/her right of appeal and accepts the decision of the Board of Directors.

Hearing Process
The hearing process provided in these By-laws is for the purpose of resolving, on an intra-professional basis, matters concerning professional competency and conduct. As such the hearing is not a Court of Law and neither the affected Practitioner, Medical Advisory Committee shall be represented by Legal Council.

The Medical Advisory Committee or Chief Executive Officer has an obligation at the hearing to present appropriate evidence and reasoning in support of the adverse recommendation or decision affecting the Practitioner. The Practitioner shall thereafter be responsible for supporting his/her challenges to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or such basis is arbitrary, unreasonable or capricious.

Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Medical Advisory Committee or Chief Executive Officer at a time convenient to itself, will conduct its deliberation outside the presence of the Practitioner for whom the hearing was convened.

The Chief Executive Officer will be responsible to advise the affected practitioner of the decision within 21 days.

The decision will be considered final. Notwithstanding any provisions of these By-laws, no Practitioner shall be entitled to more than one hearing on any one matter.

TEMPORARY PRIVILEGES
The Medical Advisory his/her Deputy may grant medical Practitioners temporary and emergency privileges. In exercise of such privileges the applicant shall act under the supervision of the Chief Executive Officer or his/her Deputy. Such temporary privileges shall be granted until his/her application has been determined.

For out of State or overseas medical practitioners who do not hold registration in the State, the Medical Advisory Committee with the approval of the State Medical Board may grant temporary accreditation. This is to allow for visits by practitioners of international standing who due to the shortness of their stay would be unable to obtain temporary registration and would thus be precluded from conducting demonstration operations.

Temporary privileges shall be immediately terminated by the Chief Executive Officer upon notice of any failure by the Practitioner to comply with Medical By-laws and Rules.

EMERGENCY PRIVILEGES
In the case of an emergency, any Medical Practitioner, to the degree permitted by his/her license, and regardless of service or status or lack thereof, shall be permitted and assisted to do everything possible for the life of a patient, using every facility of the Hospital necessary including the calling of any consultation necessary or desirable.

When the emergency position no longer exists, such Practitioner of the medical staff must request privileges necessary to continue to treat the patient. For the purpose of this section, an 'emergency' is defined as a condition in which serious permanent harm could result to the patient or in which the life of the patient is in immediate danger or where any delay in administering treatment would add to that danger.

CORRECTIVE ACTION

ROUTINE CORRECTIVE ACTION

Whenever the activities or professional conduct of any Practitioner with clinical privileges or medical staff membership are detrimental to patient safety or to the delivery of adequate patient care, or are disruptive to the Hospital operation, corrective action against such a Practitioner may be initiated by any two officers of the medical staff, or by the Chief Executive Officer.

All requests for corrective action shall be in writing, and submitted to the Chief Executive Officer. Upon receipt of the request for corrective action, the Chief Executive Officer will immediately notify the Medical Advisory Committee who will endeavour to resolve the problem through implementation of corrective action. Should this not be acceptable to the Practitioner?
The Chief Executive Officer shall require the Practitioner concerned to present their case within thirty (30) days of such notification. After this meeting, if the Management Review Committee recommends reducing or suspending medical staff membership and/or clinical privileges, then such recommendations will be made in writing by Chief Executive Officer. If the Practitioner fails to present their case, Medical Advisory Committee may take action as it sees fit.

Upon receipt of such recommendations and at the next regular scheduled meeting of Medical Advisory Committee pursuant to the recommendation shall be made. Notification of the decision shall be sent by the Chief Executive Officer to the Practitioner involved. If the decision adversely affects the medical staff membership or clinical privileges of the Practitioner involved, then the Practitioner shall have the right of appeal as outlined under of these By-laws.

SUMMARY SUSPENSION

The Medical Advisory Committee and Chief Executive Officer has the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital, to suspend all or any portion of clinical privileges of a Practitioner and such summary suspension shall become effective immediately upon imposition.

Immediately upon the imposition of the summary suspension, the Chief Executive Officer shall have the authority to provide alternative medical cover for any patients of the suspended Practitioner still in the Hospital at the time of the suspension. Within thirty (30) days following such action, the Medical Advisory Committee will have a hearing to determine whether the affected Practitioner will be reinstated. If the action taken results in the Medical Advisory Committee to reduce or suspend medical staff membership and/or clinical privileges, then the affected Practitioner is to be advised in writing by the Chief Executive Officer of such recommendation. The affected Practitioner has the right of appeal

AUTOMATIC SUSPENSION

Automatic suspension of medical membership and/or clinical privileges shall be imposed to any member of the medical staff whose name has been removed or suspended from the Medical Register. Should the registration of the suspended member be reinstated during the period of time of the appointment to the medical staff, the Management Committee may reinstate their Hospital privileges.

If the action results in the recommendation of the Medical Advisory Committee to reduce or suspend medical staff membership and/or clinical privileges, then the affected Practitioner is to be advised in writing by the Chief Executive Officer of such recommendation. The affected Practitioner has the right of appeal.

RESIGNATION
A Visiting Medical Practitioner may resign at any time, and the Medical Advisory Board reserves the right to withdraw accreditation at any time upon giving at least 14 days' notice but without necessarily giving reasons for withdrawal of those privileges.

AMENDMENT OF BY-LAWS
These By-Laws and any Regulation made pursuant to them from time to time may be amended by submission of and proposed amendment to a meeting of the Medical Advisory Board

MEDICAL ADVISORY COMMITTEE

Accountability
The Medical Advisory Committee acts in an advisory capacity of the facility.

Role and Responsibility
The committee nominees will:

- Make recommendations to the Board of Management on matters concerning clinical practice.
- Make recommendations regarding the appointment of visiting medical officers via the credentialing process, and withdrawal of those privileges should that be necessary.
- Advise on professional/ ethical issues on the part of all members of the medical staff and prescribe corrective measures if indicated.
- Support and advice on policies and procedures in order to meet medical legal requirements and current clinical practice.

Terms of reference

The two members of the Visiting Medical staff stay for 5 years. Then will encourage to other VMO to participate in this committee every 5 years.

Membership

- One from BOD
- Two members of the Visiting Medical Staff representing anaesthetists and proceduralists
- Chief Executive Officer/Director of Nursing

Meeting
The MAC will meet annually, with further meetings being called if relevant issues arise. Informal communication will support the function of the committee (e.g. phone, email)

Chairman
A formal chairman is one of the two members of the Visiting Medical Staff.

Secretary
DON will maintain records of the committee