



Bethesda Hospital

By-Laws

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1. INTRODUCTION

Bethesda Hospital

Bethesda Hospital Incorporated is a private hospital licensed to treat 104 patients. It is governed by a Board of Directors, with the Chief Executive Officer being responsible to the Board for the overall management of the hospital.

Bethesda Hospital’s mission is to demonstrate God’s love through the provision of high quality hospital and health care services in our community.

Bethesda Hospital is committed to, and seeks to promote, the following values:

Teamwork	creating an environment of unity and togetherness.
Respect	recognising and acknowledging the uniqueness and value of each other.
Integrity	a sincere demonstration of honesty and trust.
Compassion	maintaining an attitude of support which conveys a caring expression of kindness, tolerance and tenderness.
Excellence	Excelling in all that we do so that we can promote the Mission of our hospital.
Professionalism	A demonstration of pride and excellence in the services we offer.

2. PURPOSE OF THIS DOCUMENT

This document sets out the terms and conditions on which practitioners are invited to apply to be accredited to admit patients and to care for and treat patients in Bethesda Hospital.

Every accreditation applicant is required to be given a copy of this document.

These By-laws:

- Establish the principles which apply to the accreditation of Practitioners at Bethesda Hospital.
- Govern the relationship of Bethesda Hospital with its accredited Practitioners.
- Set out rules for the conduct of accredited Practitioners at Bethesda Hospital.
- Provide for the establishment of structures with Bethesda Hospital which are necessary for the delivery of quality care to its patients.
- Outline Bethesda Hospital requirements of accredited practitioners in relation to the safety and quality of care of its patients.

Responsibility for the application of these By-laws is vested in the Chief Executive Officer of Bethesda Hospital.

The Hospital Executive and the Medical Advisory Committee have a responsibility to oversee and monitor the diligent application of these By-laws. Members of these committees shall in carrying out their roles, act in accordance with these By-laws and in the best interests of the Hospital.



3. DEFINITIONS

Interpretations In these By-laws, unless inconsistent with the context:

“Accreditation” means and refers to the process of credentialing by which a Practitioner is granted authority to provide health care services at Bethesda Hospital.

“Accredited Practitioner” means a Practitioner accredited to Bethesda Hospital.

“Acts” means all Acts of Parliaments, State or Federal, and extends and includes all By-laws and regulations made there under and in force from time to time.

“Allied Health Practitioner” means and refers to physiotherapists, occupational therapists, external nursing services and social workers who practice or work or who seek to practice or work at Bethesda Hospital.

“Appeals Committee” means the committee constituted under the By-laws.

“By-laws” means these By-laws.

“Staff” means a person employed or engaged in or about the Hospital.

“Chief Executive Officer (CEO)” means the duly appointed Chief Executive Officer of Bethesda Hospital.

“Credentialing and Scope of Practice Committee” means the committee established under the By-Laws.

“Defining the Scope of Clinical Practice” and **“Clinical Privileges”** means and refers to the authority granted to a Practitioner to provide health care services as a result of the process of credentialing conducted in accordance with these By-laws.

“Dental Board” means the board established in the State which governs the registration, conduct and practice of dental practitioners in the State.

“Dental Practitioner” means a Practitioner registered as a dental practitioner under the provisions of the Dental Act 1939 (WA).

“Executive Manager Clinical and Corporate Services (EMCCS)” means the person holding the position within the Hospital or combined with another position or however titled holds primary responsibility for the conduct of nursing services within the Hospital.

“Medical Advisory Committee (MAC)” means the Medical Advisory Committee duly appointed to advise the Chief Executive Officer.

“Medical Board” means the board established in the State which governs the registration of medical practitioners.

“Medical Practitioner” means a person registered as a medical practitioner under the provisions of the Medical Act of WA.

“Policy Statements” means and refers to policy statements and directives in relation to the conduct of Accredited Practitioners or clinical practice issued by the Hospital.

“Standing Orders” means an order which is a prearranged, documented and authorised by an Accredited Medical Practitioner and which, unless otherwise specified, relates to that Practitioner’s patients. The standing order may be relied upon by staff at any time in accordance with the Hospital Policy, without prior need to contact that Practitioner.

“Clinical Quality and Safety Committee” refers to the committee which governs the clinical practices provided by all clinical staff and visiting practitioners at Bethesda Hospital. This Committee has Qualified Privilege.

4. SAFETY AND QUALITY

Bethesda Hospital's commitment to safety and quality:

- Providing the best quality care and service to all patients.
- Improving continuously the quality of patient care which it provides – both clinically and in its systems of delivery.

Bethesda Hospital strives to achieve its objectives by:

- The involvement of all staff employed by the Hospital and accredited.
- Practitioners in the process of quality improvement.
- Maintaining a comprehensive system of clinical risk management, incorporating processes of monitoring and measurement of standards of care.
- Promoting a culture which supports safety and quality through education and blame free analysis of outcomes of care.

4.1 Accredited Practitioners

To assist the Hospital in its commitment to safety and quality, all Accredited Practitioners are expected to contribute towards the continued improvement of quality of care by:

- 4.1.1** Participating in the clinical quality activities of the Hospital including responding to requests from the Clinical Quality and Safety Committee in relation to specific practice issues.
- 4.1.2** Assisting the Hospital in achieving certification standards as set or required by the Australian Council of Healthcare Standards and other bodies charged with the accreditation or licensing of the Hospital.
- 4.1.3** Participating in the Hospital Open Disclosure process in the event of a significant incident to a patient at Bethesda Hospital.
- 4.1.4** Reporting to the CEO:
 - Circumstances where the care provided at the Hospital could be improved.
 - Complaints which have been made to them in respect of the conduct of the Hospital or the quality of care provided by it.
 - Incidents which may or could lead to either claims being brought against the Hospital on the grounds of negligence, want of care or a failure to provide safe working conditions.
- 4.1.5** Comply with the By-laws and all Hospital Policy statements relevant to them.
- 4.1.6** Ensure all orders, prescriptions and other documentation which he or she writes are in clearly legible format and are timed, dated and signed.
- 4.1.7** Ensure availability when deputising for another Practitioner.



5. ACCREDITATION OF PRACTITIONERS

5.1 Accredited Practitioners

Only Practitioners who are accredited at Bethesda Hospital may admit patients or care for and treat patients at that hospital.

5.2 Care of Patients

Each Accredited Practitioner is responsible for the care and treatment of patients whom he or she admits to the Hospital.

5.3 Obtaining Accreditation

A Practitioner may apply for full accreditation by submitting a completed application form (which is provided with these By-laws) to the CEO of Bethesda Hospital. The CEO is required to submit the application to the Credentialing and Scope of Practice Committee who will endorse the credential and scope of practice. The application is then submitted to the Board of Directors for acceptance in line with the strategic direction for the Hospital.

5.4 Admission Rights

Applicants may apply for accreditation to Bethesda Hospital in any of the various accreditation categories listed on the application form, however, not all categories carry admission rights. Surgical assistants, consultant practitioners and consultant emeritus practitioners do not have the right to admit patients but may care for or treat patients admitted by other accredited practitioners with admitting rights.

Residents, Registrars or Career Medical Officers do not have the right to admit patients except where they may admit patients on the basis that treatment is provided by other accredited practitioners with admitting rights.

5.5 Term of Appointment

Applicants may be accredited for a period of up to three (3) years.

New applicants are appointment for an initial twelve month period and reviewed. Subject to satisfactory outcomes the appointment is continued for the remaining two (2) years.

5.6 Accreditation Process is Confidential

The process of accreditation and the process for any change to accreditation, including evocation or termination of accreditation, is confidential and should not be disclosed to any person not involved in the process under these By-laws.



5.7 Role of a Committee considering Credentialing

The members of the Credentialing and Scope of Practice Committee are required to consider the application and make a recommendation to the CEO whether or not to accredit the applicant.

In deciding whether or not to recommend an appointment the Credentialing and Scope of Practice Committee is required to take into consideration the following:

- Registration and conditions applied.
- Professional references.
- Training and recent experience.
- Competence and clinical judgment.
- Scope of practice applying for.
- Professional capability and knowledge.
- Current fitness to practice and good character.
- Confidence in the applicant's capability and knowledge.

5.8 Role of the Chief Executive Officer

The Board of Directors makes the final decision whether or not to accredit a Practitioner to the Hospital following recommendation from the CEO.

The CEO is required to take into account the:

- Recommendation of the Credentials Committee; and
- Business strategy of Bethesda Hospital, including its infrastructure, availability of trained support staff and ability to support the proposed scope of practice.

The CEO is required to then inform the Practitioner of the decision made in respect of that Practitioner as soon as practicable after that decision is made.

5.9 Temporary Accreditation

5.9.1 Applications for temporary accreditation are made by completing the application form and submitting it to the CEO.

5.9.2 The CEO may grant temporary accreditation for a period of up to six (6) months after the chair of the committee considering credentialing considers the application and recommends the appointment.

5.9.3 If the chair of the committee considering credentialing is not readily available then the CEO/EMCCS may consider the application and make the recommendation.

5.9.4 The criteria which the chair of the committee considering credentialing are required to consider are the same as when an application for full accreditation is being considered.

5.9.5 Temporary Accreditation ceases upon the expiration of the period for which it is granted or on the date upon which the CEO informs the applicant of the decision made in respect of the applicant's application for accreditation.

5.9.6 The period of temporary accreditation may be extended beyond six (6) months by the CEO where the Credentialing and Scope of Practice Committee has not had sufficient opportunity within that period in which to make a decision regarding the application, or wishes to defer any decision, so as to allow the applicant further time in which to satisfy it on any matter or thing concerning that application.



5.10 Full Accreditation

Before the Period of Temporary Accreditation of a Practitioner expires the Credentialing and Scope of Practice Committee:

- 5.10.1** Will review that Practitioner's accreditation having regard to all the matter and things which it is required to take into account on a Practitioner's application for accreditation in the first instance.
- 5.10.2** May seek from the Practitioner or the Chair of the MAC any information or material concerning that Practitioner on his or her practice which it considers materially relevant to the Practitioner's accreditation.
- 5.10.3** Shall make to the CEO its recommendation as to whether the accreditation of the Practitioner shall be:
 - (i) Extended to Full Accreditation; or
 - (ii) Suspended; or
 - (iii) Terminated.

For the purpose of these By-Laws "Full Accreditation" shall mean a period of not less than one (1) year nor more than three (3) years as the CEO having regard to the recommendation of the Credentialing and Scope of Practice Committee shall determine.

5.11 Refusal of Accreditation or Suspension or Termination of Accreditation

The CEO may refuse an application for accreditation at his or her sole and absolute discretion and is not required to assign any reason for so doing. The decision shall be based on:

- 5.11.1** The Practitioner has engaged in practices that are contrary to the Values of Bethesda Hospital or these By-laws; or
- 5.11.2** The Practitioner has been guilty of abuse (whether physical, sexual or verbal) or harassment or has caused unnecessary or unwarranted stress to other persons working in or visiting the Hospital; or
- 5.11.3** The conduct of the Practitioner has been or is reasonably likely to be contrary to the interests of the Hospital; or
- 5.11.4** The Practitioner is not of good repute; or
- 5.11.5** The Practitioner is not competent or appropriately skilled in the discipline or practice in which the Practitioner seeks accreditation or is accredited or practices; or
- 5.11.6** The accreditation or continued accreditation of the applicant would be contrary to the best interests of the Hospital; or
- 5.11.7** The CEO does not have confidence in the Practitioner practicing at the Hospital for any reason including but not limited to:
 - (iv) The practice, or the standard of practice, or the competence, or the general behaviour of the Practitioner;
 - (v) The ability of the Practitioner to conduct his or her practice to an appropriate standard;
 - (vi) Any matter or thing affecting the Practitioner's practice or ability to practice to an appropriate or proper standard; or
 - (vii) Any allegation of incompetence, negligence or malpractice concerning the Practitioner.

The CEO will maintain a complete record of the accreditation granted to each Practitioner.



5.12 Confidentiality

Every Practitioner including the applicant must treat as confidential the proceedings relating to the granting to Practitioners of accreditation or re-accreditation and the delineation of privileges.

5.13 Surgical Assistants

- The provision of a surgical assistant is the responsibility of the treating Practitioner.
- All surgical assistants must be accredited at Bethesda Hospital through the accreditation process.
- Each Accredited Practitioner is responsible for the conduct of each assistant and student engaged by him or her.

A record of all persons who assist in procedure will be maintained by the Hospital.

5.14 Reaccreditation

5.14.1 Process

The accreditation of all Practitioners shall be subject to a formal reaccreditation process by the Credentialing and Scope of Practice Committee at the end of each period of Full Accreditation.

5.14.2 Application

Each Accredited Practitioner who seeks reaccreditation shall:

- Obtain from the CEO the application form; and
- Complete and submit that form to the CEO no later than thirty (30) days prior to the date upon which the Accredited Practitioner's current accreditation expires; and
- Submit with the application:
 - Evidence of medical registration and insurance.
 - Evidence of his or her continuing education and professional development since the previous accreditation period.
 - Evidence of his or her professional indemnity insurance.
 - Sign the existing scope of documentation provided by the Hospital to indicate that there will be no changes in scope.

The application shall be submitted to the Credentialing and Scope of Practice Committee for recommendation and the CEO shall make a decision and inform the Practitioner of that decision as soon as is reasonably practicable after it has been made.

5.15 Lapse of Accreditation

Where a Practitioner does not seek reaccreditation or renewal of accreditation prior to the expiration of the Practitioner's period of accreditation, then that Practitioner's accreditation will lapse on the last day of the period for which that Practitioner has been accredited. Upon the lapse of his or her accreditation a Practitioner shall cease to admit patients to the Hospital and to inform any clinical functions within the Hospital.



5.16 Amendment of Privileges

An Accredited Practitioner may apply for an amendment to or extension or variation of the clinical privileges and scope of practice previously granted to him or her. The application shall be made in writing to the CEO.

The application shall be submitted to the Credentialing and Scope of Practice Committee by completing the Introduction of New Procedures form for recommendation and the CEO shall make a decision and inform the Practitioner of that decision as soon as is reasonably practicable after it has been made.

A change in privileges is not automatic and is based on the capacity of the hospital to support the change. The final decision remains with the CEO.

5.17 Review of Scope of Clinical Practice

The Credentialing and Scope of Practice Committee may, at any time and from time to time, of its own volition and shall if requested by the Medical Advisory Committee or the CEO, review the Clinical Privileges granted to a Practitioner.

5.18 Internal Review of Current Fitness

An internal review is undertaken by the CEO and the MAC who are required to make a recommendation to the CEO whether or not to continue, amend, suspend or terminate a Practitioner's accreditation based on the assessment of the Practitioner's current fitness to practice. If the practitioner concerned disputes the decision of the CEO, the Practitioner may lodge an appeal within three (3) months of the decision and request an independent review under the following clause.

5.19 External Review of Current Fitness

An external review is undertaken by a person independent of the hospital and of the accredited practitioner in question. The independent reviewer is required to provide a report to the CEO. The report will be required to contain:

- an assessment of the Practitioner's current fitness to practice;
- the confidence able to be placed in the practitioner's ability to discharge the duty of care owed to patients; and
- a recommendation to continue, amend, suspend or revoke accreditation.

The CEO makes the final decision based on the recommendation made in the report.

5.20 Review of Reaccreditation Decisions

If an accredited Practitioner disputes a decision not to reappoint the practitioner or to impose conditions or otherwise vary an appointment on reaccreditation, then the Practitioner may seek a review of the decision through the appeal process as per clause 5.18. A request for review is required to be in writing and addressed to the CEO. It is a condition of any request for review that both the Hospital and the Practitioner are bound by the final decision to be made by the Hospital Executive.



A review committee is convened by the CEO and comprises a nominee of the:

- Hospital Executive.
- Chair or Deputy Chair of the MAC who will chair the review committee and determine any question of procedure for the committee.
- Learned college of which the practitioner is a member.

The review committee is required to generally follow the procedures laid down for Bethesda Hospital Credentialing and Scope of Practice Committee set out in the *Bethesda Hospital Policy Manual*. However, meetings may be conducted electronically and the applicant is required to be given:

- (i) appropriate notice of the convening of the committee.
- (ii) the opportunity to make written or oral submissions to the committee.

Neither the Hospital nor the Practitioner may be legally represented at any Review Committee meeting.

The Review Committee will make a written recommendation to the Hospital Executive on the issues being reviewed. Bethesda Hospital has determined that the Hospital Executive makes the final decision, guided by the report.

5.21 Practitioner may request Suspension of Accreditation

A Practitioner may request the CEO to suspend accreditation for a stated period for good cause, such as study leave, so as to preserve the Practitioner's right to automatically resume exercising privileges at the end of the period without having to reapply for accreditation or without threat of termination for non-use of privileges.

6. RIGHTS AND DUTIES OF ACCREDITATION

6.1 Practitioners are required to comply with Conditions of Accreditation

An Accredited Practitioner is required to continually maintain registration with the relevant professional registration body and always comply with any special conditions set by the Hospital Executive (or by the CEO, if the accreditation is temporary).

6.2 Work within Scope of Practice

An Accredited Practitioner is required to always treat patients within the limits of that Practitioner's scope of practice approved for Bethesda Hospital.

6.3 Comply with Acts, Laws, Policies etc.

An Accredited Practitioner is required to always comply with the:

- Relevant State laws regulating private hospitals and medical practice.
- Policies and procedures of Bethesda Hospital which are available in hard copy manuals.

6.4 Patient Health Records

Reasonable endeavours are required to be made by an Accredited Practitioner to ensure that Hospital patient records comply with medical/legal requirements:

- All writings must be in clearly legible form and comply with all policies of the Hospital.
- Are adequately maintained for patients treated by the Practitioner.
- Satisfy the standard required by the Australian Council on Healthcare Standards.
- Record in the medical record of each patient all procedures conducted, all instructions given, so far as practicable, all clinical findings made and the results of all investigations conducted with respect to that patient.
- Prepare and retain an operation record of all operative procedures.
- Ensure that there are adequately detailed case notes concerning each of his or her patients at Bethesda Hospital.
- Complete discharge summaries in a timely manner with all information reasonably necessary to safely discharge a patient, as well as all data reasonably necessary for the hospital to collect revenue must be provided and included in discharge summaries.

6.5 Privacy

Bethesda Hospital manages all of the personal information in accordance with the Privacy Act (1988).

All Bethesda staff and Accredited Practitioners, who deal with or hold personal information in respect of patients which is collected or held by the Hospital, must abide by the Hospital Privacy Policy.

6.6 Release of Information

All Practitioners must keep confidential at all times all matters related to the clinical care of patients and shall not release information in relation to a patient except in accordance with the Privacy Act (1988) where the:

- (i) patient has approved in writing the release of that information;
- (ii) Practitioner is required by law to release that information; or
- (iii) information is necessary for the ongoing clinical management of the patient.

6.7 Attend patients when reasonably requested

An Accredited Practitioner is required to ensure that all reasonable requests by hospital staff are responded to in a timely manner and in particular patients are promptly attended when reasonably requested by hospital staff for good clinical reason.

An Accredited Practitioner who has a patient admitted in the hospital must at all times be contactable or have made provision for an alternative Accredited Practitioner to be contacted should the need arise.



6.8 Consent

Each Practitioner who is to undertake a procedure or treatment must:

- 6.8.1** Ensure that each patient, or the guardian of the patient in the case of a minor or for persons with an intellectual disability, who is to undergo the procedure or treatment has been informed fully of:
- The nature of the procedure.
 - The probable effects on the patient.
 - How it will affect the patient's condition.
 - Why it is considered necessary.
 - The risks attendant upon the procedure.
 - The alternative types of treatment available.
 - The likely consequences if the patient declines the procedure.
- 6.8.2** Obtain from the patient who is to undergo the procedure his or her informed written consent on the form provided by the Hospital for the purpose and ensure it is signed by the patient.
- 6.8.3** Ensure that the form of written consent is delivered to the Hospital's Admission Officer at or before the time of admission of the patient, or where that is not possible, to the nurse manager of the patient's admission ward prior to the commencement of the procedure.

6.9 Comply with accepted Professional Standards

An Accredited Practitioner is required to provide professional services with due skill, care and diligence and is also required to adhere to the generally accepted ethics and standards of personal conduct expected of health care professionals.

6.10 Maintain MDO Membership or Insurance

An Accredited Practitioner is required to:

- Either continually maintain membership of a medical defence organization in a category applicable to the services for which the practitioner is accredited or otherwise be fully insured for the practitioner's own malpractice, professional errors, omissions or negligence.
- Provide the hospital with evidence of membership or insurance annually not less than fourteen (14) days prior to expiry of any period for which he or she has insurance.

6.11 Ethical and Clinical Approval for new procedures/equipment/therapies

An Accredited Practitioner shall not, without obtaining the approval of the CEO or advice from the MAC:

- Undertake any procedure or therapy which is different from accepted practice.
- Use or employ any equipment which is new to a procedure or which is untried or experimental to that procedure.
- Must at all times act in accordance with Bethesda Hospital policies relative to the introduction of new procedures and new equipment.



An Accredited Practitioner wishing to introduce a new procedure, therapy or equipment is to make an application in writing to the Medical Advisory Committee. Where ethical clearance is deemed necessary, the applicant must produce evidence of approval from an ethics committee constituted in accordance with the NHMRC guidelines, such as Sir Charles Gairdner Hospital.

6.12 Emergency Authority

In an emergency, the CEO or his or her nominee may take such action as is considered appropriate in the interests of a patient, including, but not limited to, the arranging for the attendance of another Accredited Practitioner.

6.13 Use Bethesda Hospital name only with approval

Unless a Practitioner has the prior written approval of the CEO a practitioner may not use Bethesda Hospital letterhead or in any way hold out that the practitioner represents Bethesda Hospital.

6.14 Advise the Hospital about changed circumstances

An Accredited Practitioner is required to promptly advise the Bethesda Hospital if any of the following events occur:

- A statutory professional registration board makes an adverse finding against the practitioner.
- A statutory professional registration board revokes or suspends the practitioner's registration or places any limitation on the practitioner's registration or right to practice.
- Membership of a medical defence organisation is not renewed, or made conditional in any way, or full insurance cover is not in place for any reason.
- The practitioner's appointment as a visiting medical officer (by whatever name called) at any other hospital or day procedure centre is changed in any way.
- The practitioner is charged with or convicted of a serious criminal offence.

6.15 Use of Operating Room

Sessions for the use of operating rooms are allocated by the Hospital to Accredited Practitioners on the basis that each session will be fully utilised.

The Hospital reserves the right to:

- Modify or change the allocation of theatre sessions having regard to the utilisation and department requirements.
- Make casual bookings for the whole or part of any operating suite session which is not fully utilised.

Variations in session times may be negotiated from the standard session times with the Manager Perioperative Suite.

Whenever possible an Accredited Practitioner shall give notice to the Theatres of not less than 14 days when the operating sessions will not be used.

Notice of intent to take annual or conference leave is to be notified three (3) months prior whenever possible.

6.16 Anaesthetics (Other than local)

Every patient undergoing anaesthesia in the Hospital shall be seen by his or her anaesthetist at an appropriate time prior to the anaesthetic being administered and an ASA score completed and recorded.

All anaesthetics administered in the Hospital shall comply with all standards of the Australia and New Zealand College of Anaesthetists.

The Anaesthetist shall be available to return to a patient's care for 24 hours following a procedure or ensure cover by another accredited anaesthetist.

Anaesthetic records must be completed by the end of each procedure and must include details of:

- All drugs administered and procedures undertaken as part of the anaesthetic.
- The patient's condition and observations during the anaesthetic.
- Post anaesthetic observations and care including information as to a contact telephone number for the anaesthetist in the event of any complication or concern.

6.17 Standing Orders

Each Accredited Practitioner may provide Standing Orders for use in wards once approved by the Medical Advisory Committee. Standing orders must:

- Be reviewed and signed each year by the Accredited Practitioner.
- Be consistent with the policies and practices of the Hospital.
- Include written instructions for post operative or post procedure management of patients.
- Be consistent with the guidelines of the relevant professional college.
- Not contravene any Laws.
- Not include any medications.

7. THERAPEUTIC ABORTIONS

It is recommended that, in the interests of providing holistic care to the patient and family, patients requiring a therapeutic abortion be referred to a specialist gynaecological medical facility where psycho-social and spiritual supports are readily available.

However, therapeutic abortions may be carried out at Bethesda Hospital in accordance with the Health Act 1911 – Section 334 Performance of Abortions and the following conditions:

7.1 Medical Reasons

The indication for the termination is for medical reasons then the Executive Manager Clinical and Corporate Services must receive two Medical Certificates, one of which must be issued by a Registered Specialist, stating on what grounds the termination is recommended.

7.2 Psychiatric Reasons

The indication for the termination is for psychiatric reasons then the Executive Manager Clinical and Corporate Services must receive a Medical Certificate from each of two (2) Psychiatrists, who are not in partnership, stating on what grounds the termination is recommended.

7.3 Clinical and Investigatory Evidence

Clinical and investigatory evidence indicates that a pregnancy has failed to progress or is undergoing foetal degeneration. The Executive Manager Clinical and Corporate Services must receive two Medical Certificates, one of which must be from a Registered Specialist stating the diagnosis and on what grounds the termination is recommended.

7.4 Foetal Abnormality

A diagnosis of foetal abnormality is made of sufficient severity that the survival of the child after birth is highly unlikely. The Executive Manager Clinical and Corporate Services must receive two Medical Certificates, one of which must be from a Registered Specialist stating on what grounds the termination is recommended.

8. MEDICAL ADVISORY COMMITTEE

8.1 Requirement for Medical Advisory Committee

There shall be a Medical Advisory Committee for the purpose of advising the CEO with respect to the following:

- 8.1.1** Making clinical policy, planning and review of the clinical procedures of Bethesda Hospital.
- 8.1.2** Ensuring the appropriate conditions for clinical procedures within the Hospital.
- 8.1.3** The introduction of new surgical and medical procedures within the Hospital.
- 8.1.4** The conduct of the process for delineation of clinical privileges.
- 8.1.5** The review of matters relating to clinical practice and accreditation.
- 8.1.6** Dealing with managing and prescribing the practice and behaviour of impaired and disruptive medical practitioners.
- 8.1.7** All matters relating to safety and quality of patient care.
- 8.1.8** Issues of competency of Practitioners.

8.2 Insurance cover for Committees

Bethesda Hospital confirms that the indemnity provided under its medical malpractice and professional indemnity cover specifically extends to the Medical Advisory Committee and the Credentialing and Scope of Practice Committee considering credentialing.



8.3 Membership of the MAC

The MAC will comprise persons who are:

- Representative of the specialty groups as determined by the CEO and elected from the Accredited Medical Practitioners.
- Appointed by the CEO.

The CEO and the EMCCS shall be members of the MAC, *ex officio*.

The CEO shall at their discretion determine:

- The number of persons who are to comprise the MAC from time to time.
- The process by which persons are to be elected or nominated to the MAC.
- The CEO may institute a process to facilitate the election of persons from each of the principle clinical specialties.

8.4 Obligation to keep Confidential

Members of Committees shall not divulge or make known to any person other than to members of the relevant department or committee or others having a right to know the same information concerning or in relation to:

- The Hospital and its committees and their operations.
- The contents of papers, manuals, instruments, documents and records which they may have relating to the Hospital or to any aspect of its management or finances or any committees.